STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/4/16 through 10/6/16. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety code survey/report will follow. The census in this 190 certified bed facility was 162 at the time of the survey. The survey sample consisted of 26 current resident reviews (Residents #1 through #22 and #29 through #32) and six closed record reviews (Residents #23 through #28).	F 000	*Ashland Nursing and Rehabilitation ("Facility") is filing this plan of correction for purposes of regulatory compliance. The Facility is submitting this plan of correction to comply with the applicable law. The submission of the plan of correction does not represent an admission or statement of agreement with respect to the alleged deficiencies.*	
F 160 SS=D	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to convey resident funds upon death for one of three closed record reviews, Resident #25. Resident #25 expired on 8/20/16 and the resident fund has not been dispersed at the time of the survey, a total of 46 days.	F 160	RECEIVED NOV 03 2016 VDH/OLC F160 , 12VAC5-371-160E (1) Resident #25's refund has been issued. (2) All residents have the potential to be affected by deficient financial practices. The facility will conduct a 100% audit of all resident trust funds to identify other residents who have been discharged or expired since the last annual survey.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: EKMCe — TITLE: Administrator — (X6) DATE: 10·26·16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 160	Continued From page 1	F 160		

The findings include:

Resident #25 was admitted to the facility on 3/25/16 with diagnoses that included but were not limited to: atrial fibrillation, dementia, macular degeneration, diabetes, anemia, gastritis and impulsive disorder.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/1/16, coded the resident as being severely impaired to make cognitive daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living.

Review of the clinical record revealed a nurse's note dated 8/20/16 at 8:10 a.m. that documented Resident #25 had expired.

On 10/5/16 at 3:22 p.m. a review of Resident #25's fund account was conducted. The "Resident Statement Landscape" documented on 10/3/16, the resident fund still had $42.52.

An interview was conducted with administrative staff member (ASM) #3, the regional business office manager, on 10/5/16 at 3:22 p.m. When asked what the status of the account was, ASM #3 stated, "It's frozen, there can be no transactions made to it." When asked the procedure for closing a resident fund account upon the resident's death, ASM #3 stated, "We have to close it within 30 days of the death. We have to wait for the funeral bill to see if the monies go there or to the family." ASM #3 was asked when the money is to be sent to either the family or funeral home. ASM #3 stated, "Within

(3) The facility will: (a) review policies/procedures on resident rights as it relates to refunding money after discharge. ED/designee will educate Business office manager on the above policy (c) The Business Office Manager or designee will receive discharge information 5 x weekly for 1 month and will refund any money due within 30 days then weekly x1 month.

(4) The Quality Assurance/Performance Improvement (QAPI) team will conduct periodic audits to identify any noncompliance.

Completion Date: 11-7-16

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F 160	Continued From page 2 30 days." When asked if it had been over 30 days since Resident #25 expired, OSM #3 stated, "Yes, but we don't have the funeral bill." When asked why this had not been processed, ASM #3 stated, "I'm only filling in, the previous business office manager's last day was 8/19/16." The facility policy, "Resident Trust Fund" documented in part, "Upon the death or discharge of a resident with personal funds on deposit with the facility that are less than the Medicaid Resource Level for a Medicaid resident, the Business Office must deliver all remaining monies to the appropriate person by processing a refund within thirty (30) days (Federal Regulation 483.10)." The administrator and ASM #4, the regional director of nursing services, were made aware of the above concern on 10/5/16 at 5:12 p.m. No further information was obtained prior to exit.	F 160		
F 167 SS=D	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced	F 167	F 167, 12VAC5-371-110A (1) Postings regarding the location or availability of the most recent survey results have been placed throughout the facility.	

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F 167	Continued From page 3	F 167		

by:
Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to post the location and availability of the current survey results.

Observations during the survey failed to reveal any postings regarding the location or availability of the most recent survey results.

The findings include:

On 10/4/16 al 2:00 p.m. and 10/5/16 at 10:00 a.m., observation of the facility's 2015 survey results was conducted. The results were located in a three ring binder on a table in the front lobby of the facility. The front of the binder was labeled, "(name of Facility) Survey Results." No further notices of the location of the survey results were posted anywhere else in the lobby.

On 10/5/16 at 11:00 a.m., a group meeting was conducted with four residents. When asked if they knew where the survey results were located, all four residents stated, "No."

Observations of Units Wing # 1, Wing # 2 and Wing # 3 on 10/5/16 at approximately 3:00 p.m. failed to evidence a notice regarding the location of survey results.

On 10/6/16 at 8:30 a.m., an interview was conducted with ASM (administrative staff member) # 1, the administrator. ASM # 1 stated the survey results were located in a binder on a table in the facility lobby. When asked if there was information elsewhere in the facility indicating

(2) No residents were affected by this deficient practice.

(3) ED/designee will educate residents and staff concerning the location of survey results.

(4) The Quality Assurance/Performance Improvement (QAPI) team will conduct periodic audits to identify any noncompliance.

Completion Date: 11-7-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED
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F 167	Continued From page 4 the location of the survey results ASM # 1 stated, "No. There should be a sign on each unit." The facility's policy "Virginia Resident's Rights and Responsibilities" documented, "Examination of your Records and Survey Results: B. To examine the results of the most recent survey of the facility conducted by Federal or state surveyors and any plan of correction in effect with respect to the facility." On 10/6/16 at 11:20 a.m., ASM # 1, the administrator and ASM # 2, the director of nursing, were made aware of the above findings. No further information was presented prior to exit.	F 167		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview and facitity document review, it was determined that the facility staff failed to implement abuse policies to ensure complete a thorough background check for one of five employee records reviewed, CNA (certified nursing assistant) #20. The facility staff did not have a completed, signed sworn statement in CNA #20's employee record prior to the date of hire per the facility abuse policy.	F 226	F 226, (1) C.N.A. #20 has signed and dated the sworn statement. (2) Residents that reside in the facility have the potential to be affected by failure to perform employee screenings. The facility will conduct an audit of 100% of current employee records to ensure that all sworn statements have been signed. (3) ED/designee will educate HR Director and management team on the policy for employment screening prior to hire. The Executive Director or designee will review all new hires during orientation to ensure completion of sworn statements weekly for four weeks and monthly for three months. (4) The Quality Assurance/Performance Improvement (QAPI) team will conduct periodic audits to identify any noncompliance. Completion Date: 11-7-16	

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F 226	Continued From page 5	F 226		

The findings include:
CNA #20 was hired in the facility on 8/8/16. A review of CNA #20's employee record during the survey process revealed, in part, that CNA #20's employee record did not contain a signed/dated sworn statement prior to the date of hire.
On 10/6/16 at 12:58 p.m. OSM (other staff member) #18 was asked to provide a copy of CNA #20's sworn statement.
On 10/6/16 at approximately 1:15 p.m. OSM #18, in the presence of ASM (administrative staff member) #1, the administrator, stated that he did not have a signed/dated copy of the sworn statement for CNA #20. OSM #18 further stated that he had a copy on which he had signed but CNA #20 had not signed / dated the form. OSM #18 was asked to describe the process. OSM #18 stated, "Prior to employment I obtain references, a license verification, background check (to include the sworn statement) and a drug screen." When asked if he had followed this process with CNA #20, OSM #18 stated he thought he had but she (CNA #20) did not sign the sworn statement.
A review of the facility policy "Resident Abuse" revealed, in part, the following documentation:
"Screening: Persons applying for employment with a The (sic) Company facility will be screened for a history of abuse, neglect, or mistreating residents to include: References from previous or current employers (with applicant permission). Criminal Background check. Abuse check with appropriate licensing board and registries, prior to hire. Sworn Disclosure Statement prior to hire. Verify license or registration prior to hire."
No further information was provided prior to the end of the survey process.

F 241 483.15(a) DIGNITY AND RESPECT OF — F 241

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F 241 SS=D	Continued From page 6 INDIVIDUALITY	F 241		

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview and clinical record review, it was determined that the facility staff failed to promote care in a manner to enhance dignity for two of 32 residents in the survey sample, Residents #15 and #13

1. The facility staff failed to provide incontinence care to Resident #15 in a timely manner. CNA (certified nursing assistant) #12 stated she knew the resident was soiled at approximately 10:00 a.m. The CNA did not return to provide incontinence care until 2:14 p.m. Resident #15 stated being left soiled for extended periods of time made her feel angry and sad.

2. Facility staff failed to provide incontinence care in a timely manner for Resident # 13.
On 10/5/16 at 2:45 p.m. during an interview with Resident # 13 regarding her incontinence care Resident # 13 stated, "It makes me frustrated and it's unacceptable."

The findings include:

1. The facility staff failed to provide incontinence care to Resident #15 in a timely manner. CNA

F 241

1. Incontinence care was provided to resident #13 and #15 during the survey process. Residents #13 and #15 are receiving incontinent care in a timely manner.
2. Residents' who reside in the facility have the potential to be affected by not receiving incontinent care. Residents have been observed and staff is responding to calls for assistance and administering incontinent care in a timely manner.
3. Staff education has been provided on incontinence care and timely call bell response. Audits to be done 3x a week x1 month and then weekly x2 months on call bell response and providing care by the DCS/designee.
4. Director of Clinical Services /designee will report results of findings of audits to the Quality Assurance/Performance Improvement (QAPI) monthly for review and recommendations

Completion Date: 11-7-16

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#12 stated she knew the resident was soiled at approximately 10:00 a.m. The CNA did not return to provide incontinence care until 2:14 p.m.

Resident #15 was admitted to the facility on 7/10/15. Resident #15's diagnoses included but were not limited to: a fractured vertebra, morbid obesity and diabetes. Resident #15's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/24/16, coded the resident as scoring a 15 out of a possible 15 on the brief interview for mental status, indicating the resident was cognitively intact. Section G coded Resident #15 as requiring extensive assistance of one staff with bed mobility, locomotion, dressing, toilet use, personal hygiene and bathing. Section H documented the resident was frequently incontinent of bowel and bladder.

Resident #15's comprehensive care plan with an implementation date of 9/13/16 documented, "The resident has altered bowel elimination...check resident every approx (approximate) q 2 hrs (every two hours) & PRN (as needed)...Provide pericare after each incontinent episode...The resident has altered bladder elimination...Check for incontinence. Wash, rinse and dry soiled areas..."

On 10/4/16 at 1:30 p.m., Resident #15 was observed lying in bed. The resident stated she had been waiting to get her "diaper" changed since 7:00 a.m. Resident #15 stated "people come in then someone else catches them. I guess they don't have enough staff." The smell of feces and urine was noted in the room. At 1:35 p.m., Resident #15 was asked to ring her call bell. At 1:45 p.m., an employee entered the resident's

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room; however, the resident didn't report to the employee that she needed incontinence care. At 1:50 p.m., Resident #15 was asked why she didn't tell the employee that she needed incontinence care. Resident #15 stated she had never seen that employee. At this time, Resident #15 was asked to ring her call bell and tell staff she needed incontinence care. Resident #15 rang her call bell and CNA (certified nursing assistant) #19 immediately entered the room. Resident #15 told CNA #19 she needed to be changed. CNA #19 stated she would grab some supplies and be right back. At 1:57 p.m., CNA #19 returned to the room and stated she needed to go get help. At 2:01 p.m., CNA #19 returned to the room with CNA #18 and provided incontinence care to Resident #15. Observation of incontinence care revealed Resident #15's entire disposable brief was soiled with urine through the disposable pads underneath the resident. Feces was observed smeared all over the resident's bottom. No open areas were observed on the resident's bottom. CNA #19 asked the resident if she had been washed that morning and the resident stated she had not been touched that day. CNA #18 and CNA #19 were asked who was responsible for caring for Resident #15 that shift. CNA #19 stated CNA #12 was supposed to care for Resident #15. At 2:14 p.m., CNA #12 entered Resident #15's rooms with disposable briefs and pads. CNA #12 placed the supplies in the resident's closet and exited the room.

On 10/4/16 at 2:30 p.m., an interview was conducted with CNA #18. CNA #18 was asked if the facility employed enough staff to care for residents. CNA #18 stated, "Yes." CNA #18 was asked if she had provided any care for Resident

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#15 that shift (other than the incontinence care just provided). CNA #18 stated she had not.

On 10/4/16 at 2:33 p.m., an interview was conducted with CNA #19. CNA #19 was asked if the facility employed enough staff to care for residents. CNA #19 stated there was enough staff. CNA #19 was asked if she had provided any care for Resident #15 that shift (other than the incontinence care just provided). CNA #19 stated she had only delivered a meal tray to the resident.

On 10/4/16 at 2:40 p.m., an interview was conducted with CNA #12 (the CNA responsible for caring for Resident #15 that shift). CNA #12 was asked to describe the care she had provided for Resident #15 that day. CNA #12 stated she served breakfast, changed Resident #15's brief around 9:00 a.m., put the resident's feet up, and washed the resident. CNA #12 was asked how often Resident #15's brief was changed. CNA #12 stated she checks the resident's brief every hour and a half. CNA #12 stated she checked Resident #15 at "10ish" and the resident was soiled with urine. CNA #12 stated she then became "side tracked" by other residents and confirmed she had not provided care for Resident #15 from "10ish" until she entered the room when this surveyor was observing two other CNAs providing incontinence care to the resident (at approximately 2:14 p.m.).

On 10/4/16 at 2:45 p.m., an interview was conducted with CNA #1 (another CNA working on Resident #15's unit). CNA #1 stated she had not provided any care for the resident during that shift.

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On 10/4/16 at 2:47 p.m., an interview was conducted with CNA #16 (another CNA working on Resident #15's unit). CNA #16 stated she had not provided any care for the resident during that shift.

On 10/4/16 at 4:40 p.m., another interview was conducted with Resident #15. Resident #15 was asked to describe all of the care that had been provided for her that day. Resident #15 stated someone came into her room at approximately 6:30 a.m. or 7:00 a.m. and asked if she was wet. Resident #15 stated she reported to the woman that she didn't feel anything. Resident #15 stated someone came into her room and brought her meal tray then this surveyor saw all other care provided. Resident #15 was asked how she felt when she was left soiled for an extended period of time. Resident #15 stated that situation didn't happen very often but it makes her wonder why and what had she done. Resident #15 stated she had always been active but there was nothing she could do. Resident #15 stated that makes her feel angry but mostly makes her feel sad.

On 10/5/16 at 9:20 a.m., Resident #15 was lying in bed. CNA #12 entered the room and told the resident she was going to "check her again." After the CNA left the room, Resident #15 stated the CNA stated she was going to care for Resident #15 first each day.

On 10/5/16 at 1:45 p.m., CNA #12 stated during the previous day, she had to serve breakfast in the dining room and had to pass all of the lunch trays on her hall.

On 10/6/16 at 7:52 a.m., an interview was conducted with LPN (licensed practical nurse) #6.

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LPN #6 was asked how she would feel if she told a CNA she was soiled at approximately 10:00 a.m., and the CNA didn't return to provide incontinence care until approximately 2:00 p.m. LPN #6 stated, "Terrible; horrible."

On 10/6/16 at 11:25 a.m., ASM (administrative staff member) #2 (the director of nursing) was made aware of the above findings.

On 10/6/16 at 1:40 p.m., ASM #1 (the administrator) was made aware of the above findings.

The facility policy titled, "Resident Rights" documented in part, "The facility will ensure that the resident is not deprived of his/her rights. The resident's rights may not be used as a reward or sanction. Waiver of any resident right shall be void. Procedure: Resident Rights...3. A resident shall be treated with dignity and respect..."

No further information was presented prior to exit.

2. Facility staff failed to provide incontinence care in a timely manner for Resident # 13.

Resident # 13 was admitted to the facility on 1/28/14 with diagnoses that included but were not limited to: coronary artery disease (1), depression, hypertension (2), gastroparesis (3), gastroesophageal reflux disease (4), shortness of breath, anxiety (5), cerebrovascular disease (6), dysphagia (7), quadriplegia (8), and abnormal posture.

Resident # 13's most recent MDS (minimum data set) a quarterly assessment, with an assessment reference date (ARD) of 8/18/16, coded the

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resident as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 being cognitively intact for daily decision making. Resident # 13 was coded as being totally dependent of two staff members for activities of daily living and severely impaired of vision.

On 10/5/16 at 8:30 a.m. an observation of Resident # 13 was conducted. Resident # 13 was observed lying in bed, the head of the bed elevated, a CNA (certified nursing assistant) present on the right side of Resident # 13's bed. The over bed table was on the right side of Resident # 13's bed with the breakfast tray on it and the CNA was feeding Resident # 13.

On 10/5/16 at 10:25 a.m. an interview was conducted with Resident # 13. During the interview Resident # 13 stated that she required incontinence care. When asked if she had told the staff that needed care, Resident # 13 stated that she had told the CNA who was assisting her with breakfast. Resident # 13 further stated, "I haven't been cleaned up. I told them right after breakfast." When asked who she told about requiring incontinence care Resident # 13 stated, (Name of CNA # 5). It happens all the time, I have to wait."

On 10/5/16 the following observations were conducted: At 11:00 a.m., CNA #5 walked into Resident # 13's room with chuck pads and supplies for incontinent care. She set them down on the bedside table and left the room. At 11:15 a.m., CNA #5 reentered the room with CNA # 24. They shut the door behind them. At 11:26 a.m. CNA # 24 came out of the resident's room. When asked if he was helping with incontinence care for Resident # 13, CNA #24, "Yes." At 11:45 a.m.,

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CNA # 5 exited the room with a plastic bag of soiled linen.

On 10/6/16 at 9:20 a.m. an interview was conducted CNA # 5. When asked if she assisted Resident # 13 with breakfast on 10/5/16, CNA # 5 stated, "Yes." When asked if Resident # 13 had told her that she needed incontinence care, CNA # 5 stated, "Yes." When asked what she told Resident # 13, CNA # 5 stated, "I told her [Resident # 13] that I had to feed other residents and should be back after feeding other residents and picking up the trays and I still had to wait for another person because (Resident # 13) requires two to change her." When asked about the condition of Resident # 13 when incontinence care was provided, CNA # 5 stated, "She didn't have a bowel movement but she was wet." When asked about the procedure for incontinence care, CNA # 5 stated, "If the resident is not a two person, check the resident immediately. If the resident requires two people I have to wait for someone else who is available to help."

The comprehensive care plan for Resident # 13 with a review date of 9/8/16 documented, "Category: Elimination GU [genitourinary]. Focus: Resident has altered bladder elimination. Etiologies (causes): Other: specify CKD (chronic kidney disease). Physical limitations. Impaired mobility. Self-care deficit. Incontinence." Under "Approaches/Interventions" it documented, "Check for incontinence. Incontinent brief, pads continually." "Category: ADL (activities of daily living). Focus: Resident has an ADL self-care performance deficit. Etiologies: Limited ROM (range of motion). Musculoskeletal impairment. Disease process (specify) contractures. Medical

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diagnosis (specify) CVA [cerebral vascular accident] with quadriplegia UE (upper extremity) contractures. As evidenced by: ... Unable to toilet. .. "The resident will receive appropriate staff support with bed mobility, transfers, eating, dressing, toilet use."

On 10/5/16 at 2:45 p.m. during an interview with Resident # 13 regarding her incontinence care Resident # 13 stated, "It makes me frustrated and it's unacceptable."

On 10/6/16 at 10:40 a.m. an interview was conducted with LPN (licensed practical nurse) # 3. When asked how long a resident should wait to receive incontinence care LPN # 3 stated, "No more than a thirty minute wait. If you can get in right away then it should be done."

On 10/6/16 at 10:55 a.m. an interview was conducted with LPN # 4, unit manager. When asked how long a resident should wait to receive incontinence care LPN # 4 stated, "It should be done immediately. The resident should not have to wait."

On 10/6/16 at 11:20 a.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing. When asked how long a resident should wait to receive incontinence care ASM # 2 stated, "A resident should be changed immediately."

On 10/6/16 at 11:20 a.m., ASM # 1, the administrator and ASM # 2, the director of nursing, were made aware of the above findings.

No further information was presented prior to exit.

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References:

(1) Common type of heart disease. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html.

(2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(3) A condition that reduces the ability of the stomach to empty its contents. It does not involve a blockage (obstruction). This information was obtained from the website: https://medlineplus.gov/ency/article/000297.htm.

(4) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(5) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

(6) A stroke. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000726.htm.

(7) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

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F 241	Continued From page 16 (8) Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. Paralysis of the lower half of your body, including both legs, is called paraplegia. Paralysis of the arms and legs is quadriplegia. This information was obtained from the website: https://medlineplus.gov/paralysis.html.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to place a call ball in an accessible place for one of 32 residents in the survey sample, Resident # 13. The facility staff failed to position Resident # 13's adaptive call bell, a Breathcall Cord [call bell activated by a puff of air by the user](1) within reach. The findings include:	F 246	1. Resident #13 has her call bell positioned properly allowing her to call for assistance. 2. Residents that reside in this facility have the potential to be affected by not having call bell access. Observations have been conducted by the DCS throughout the facility and no call bells were noted to be out of reach of residents. 3. Staff education has been provided on the importance of ensuring call bells are in reach for all residents. Audits will be conducted daily x1 month and then weekly x2 months to ensure compliance. 4. Director of Clinical Services /designee will report results of audits to the Quality Assurance/Performance Improvement (QAPI) monthly for review and recommendations.	

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Resident # 13 was admitted to the facility on 1/28/14 with diagnoses that included but were not limited to: coronary artery disease (2), depression, hypertension (3), gastroparesis (4), gastroesophageal reflux disease (5), shortness of breath, anxiety (6), cerebrovascular disease (7), dysphagia (8), quadriplegia (9) and abnormal posture.

Resident # 13's most recent MDS (minimum data set) a quarterly assessment, with an assessment reference date (ARD) of 8/18/16, coded the resident as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 being cognitively intact for daily decision making. Resident # 13 was coded as being totally dependent of two staff members for activities of daily living and severely impaired of vision.

On 10/4/16 at 1:45 p.m. an observation of Resident # 13 revealed she was lying in bed awake with the head of the bed slightly raised. Observation of the Breathcall Cord revealed it was mounted on the upper left bed rail and extended over Resident # 13's left chest and above the level of her chin. When Resident # 13 was asked if she could locate and activate the call bell, Resident # 13 moved her head right and left and protruded her tongue searching for the call bell. Resident # 13 was also observed to be able raise her head only slightly, approximately two to three inches from her pillow. After several attempts Resident # 13 was unable to locate and activate the call bell.

On 10/4/16 at 4:20 p.m. an observation of Resident # 13 revealed she was lying in bed awake with the head of the bed slightly raised.

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Observation of the Breathcall Cord revealed it was mounted on the upper left bed rail and extended over Resident # 13's left chest and above the level of her chin. When Resident # 13 was asked if she could locate and activate the call bell, Resident # 13 moved her head right and left and protruded her tongue searching for the call bell. Resident # 13 was also observed to be able raise her head only slightly, approximately two to three inches from her pillow. After several attempts Resident # 13 was unable to locate and activate the call bell.

On 10/5/16 at 9:15 a.m. an observation of Resident # 13 revealed she was lying in bed awake with the head of the bed raised. Observation of the Breathcall Cord revealed it was mounted on the upper left bed rail and extended over Resident # 13's left chest and above the level of her head. When Resident # 13 was asked if she could locate and activate the call bell, Resident # 13 moved her head right and left and protruded her tongue searching for the call bell. After several attempts Resident # 13 was unable to locate and activate the call bell.

On 10/5/16 the following observations were conducted: At 10:49 a.m., Resident # 13 was lying supine in the bed and her Breathcall Cord was on the right side of her. The resident could not reach the call bell. At 11:00 a.m., CNA #5 walked into Resident # 13's room with chuck pads and supplies for incontinent care. She set them down on the bedside table and left the room. At 11:15 a.m., CNA #5 reentered the room with CNA # 24. They shut the door behind them. At 11:45 a.m., CNA # 5 exited the room with a plastic bag of soiled linen. At 11:46 a.m., Resident # 13 was observed to be lying in a

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supine position and her Breathcall Cord was out of reach. When asked if she could reach her Breathcall Cord she stated, "I don't think I can reach it."

On 10/5/16 at 1:55 p.m. an observation of Resident # 13 revealed she was lying in bed awake with the head of the bed raised. Observation of the Breathcall Cord revealed it was mounted on the upper left bed rail and extended over Resident # 13's left chest and above the level of her head. When Resident # 13 was asked if she could locate and activate the call bell, Resident # 13 moved her head right and left and protruded her tongue searching for the call bell. After several attempts Resident # 13 was unable to locate and activate the call bell.

On 10/6/16 at 8:00 a.m. an observation of Resident # 13 revealed she was lying in bed awake with the head of the bed slightly raised. Observation of the Breathcall Cord revealed the mouth piece missing from the extended arm and was lying on the bed above Resident # 13's right shoulder.

On 10/6/16 at 8:40 a.m. a CNA entered Resident # 13's room and spoke to her about what was going to be served on breakfast tray and then left the room. An observation of the Breathcall Cord immediately after the CNA left the room revealed the mouth piece missing from the extended arm and was lying on the bed above Resident # 13's right shoulder.

On 10/6/16 at 8:45 a.m. a CNA entered Resident # 13's room and assisted Resident # 13 with breakfast. At 9:00 a.m. the CNA exited Resident # 13's room. An observation of the Breathcall

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Cord immediately after the CNA left the room revealed the mouth piece was replaced on the extended arm and positioned next to Resident # 13's right cheek. When asked to locate and activate the call bell Resident # 13 moved her head to the right pushing the call bell down to the right her right side, putting the call bell out of her reach. Resident # 13 stated that she couldn't locate the call bell.

The comprehensive care plan for Resident # 13 with a review date of 9/8/16 documented, "Focus/Category: Safety." Under "Approaches/Interventions" it documented, "Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed."

On 10/4/16 at 4:20 p.m. an interview was conducted with Resident # 13. When asked about her vision Resident # 13 stated she could not see faces but only shades and the light from the television but not the picture. When asked if she could see the call bell to blow into it, Resident # 13 stated, "No."

On 10/5/16 at 2:45 p.m. an interview was conducted with Resident # 13 regarding her access to the call bell. Resident # 13 stated, "I have to holler for help or I'll wait for someone coming down the hall and call for help." When asked how she felt about not being able to access the call bell Resident # 13 stated "I feel frustrated."

On 10/6/16 at 9:20 a.m. an interview was conducted CNA # 5. When asked if she was assigned as Resident # 13's CNA on 10/5/16 from 7:00 a.m. to 3:00 p.m., CNA # 5 stated,

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"Yes." When asked about the call bell for Resident # 13, CNA # 5 stated, "The call bell should be close to her mouth so she can reach it with her lips and blow into it." When asked if she checked to see that Resident # 13 could reach and activate the call bell before leaving her room, CNA # 5 stated, "No." When informed of the above observations of the call bell being out of Resident # 13's reach on 10/5/15, CNA # 5 stated, "I can't explain why it wasn't in her reach."

On 10/6/16 at 10:40 a.m. an interview was conducted with LPN (licensed practical nurse) # 3. When asked about the call bell for Resident # 13, LPN # 3 stated, "The call bell should be positioned in front of her lips so she can feel it and blow into it. It should be checked for placement every two hours." LPN # 3 further stated that Resident # 13 will call out for help. When asked if having Resident #13 call out for help was appropriate, LPN # 3 stated, "No. She should be able to use the call bell."

On 10/6/16 at 10:45 a.m. an interview was conducted with CNA # 4. When asked if she had entered Resident # 13's room before breakfast, CNA # 4 stated, "Yes." When asked about the call bell for Resident # 13, CNA # 4 stated, "I didn't notice the mouth piece was missing when I was in the room the first time. When I finished her breakfast I found it and put it on. I should have checked the call bell before I left. It should be checked every two hours. When asked if she checked that Resident # 13 could locate and activate the call bell before leaving the room, CNA # 4 stated, "I didn't have her try to activate it."

On 10/6/16 at 10:55 a.m. an interview was

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conducted with LPN # 4, unit manager. When asked about the call bell for Resident # 13, LPN # 4 stated, "The call bell should be positioned directly in front of her mouth and they should check the placement before leaving the room."

On 10/6/16 at 11:20 a.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing. When asked about the call bell for Resident # 13, ASM # 2 stated, "It should be checked for placement and function."

On 10/6/16 at 11:20 a.m., ASM # 1, the administrator and ASM # 2, the director of nursing, were made aware of the above findings.

No further information was presented prior to exit.

Reference:

(1) Breathcall Cord. Pneumatic (operated by air or gas under pressure) call cord uses a non-electric means of activation for patients that are unable to use standard call devices and require minimum exertion. Activation is by a simple puff of air into the device's disposable breath tube. It is equipped with a heavy-duty clamp that is able to mount on virtually any headboard, bed rail or tabletop. This information was obtained from the website: info@criticalalert.com.

(2) Common type of heart disease. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html.

(3) High blood pressure. This information was

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obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(4) A condition that reduces the ability of the stomach to empty its contents. It does not involve a blockage (obstruction). This information was obtained from the website: https://medlineplus.gov/ency/article/000297.htm.

(5) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(6) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

(7) A stroke. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000726.htm.

(8) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(9) Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. Paralysis of the lower half of your body, including both legs, is called paraplegia. Paralysis of the arms and legs is quadriplegia.

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F 246	Continued From page 24 This information was obtained from the website: https://medlineplus.gov/paralysis.html.	F 246		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide notice prior to a room change for one of 32 residents in the survey sample, Resident #3. The facility staff failed to notify Resident #3 of a pending room change, and to show him the new room prior to the move on 6/21/16. The findings include: Resident #3 was admitted to the facility on 8/31/15, and most recently readmitted on 11/13/15, with diagnoses including, but not limited to: multiple sclerosis (1), cognitive impairment, contractures (2), and diabetes. On the most recent MDS (minimum data set), a significant change assessment with an assessment reference date 9/4/16, Resident #3 was coded as having no cognitive impairment for making daily decisions. A review of the social services progress notes for Resident #3 revealed, in part, the following note, written 6/22/16 and signed by OSM (other staff	F 247	F247 (1) Resident #3 is pleased with his room assignment. (2)) All residents have the potential to be affected by deficient notification practices. The facility will conduct an audit of 100% of resident medical records to identify those residents who had a room change. Concerns identified will be promptly addressed and as appropriate. (3) ED/designee will educate management team of room change policy and resident notification. Social Services will receive all requests for room changes and complete a form to indicate all steps in the protocol are completed. The Executive Director or designee will monitor the forms weekly for a month and monthly for three months.	

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F 247	Continued From page 25 member) #14, the social services director: "It was reported to writer on today that the patient was transferred to [number of new room] due to bed management. Per the admissions coordinator, who contacted via telephone the patient's RP (responsible party)/sister, [name of RP], to get her consent and permission for the room transfer; which the patient's RP did so (sic). Writer spoke with the patient's sister via telephone to confirm that she was made aware of the room transfer that took place on 6/21/16 and the patient's sister confirmed that she was advised of the room transfer and she was in agreement with the room transfer. As noted above, the patient was transferred from [old room number] to [new room number]. SW (social worker) to continue to continue (sic) to monitor patient and provide support. Writer encouraged the patient and his sister to outreach as needed." A review of the comprehensive care plan for Resident #3 dated 9/16/16 and most recently updated on 9/22/16 revealed nothing related to the resident's room changes. On 10/6/16 at 9:40 a.m., OSM #14 was interviewed. She stated that residents are moved for "bed management" most often to facilitate appropriate placements for residents being admitted from the hospital (needs to include appropriate gender and isolation status). She stated if a change is needed, the social worker goes to the resident and asks the resident's permission. She stated the social worker also speaks with the RP. She stated the social worker shows the resident the new room, and introduces the resident to the new roommate and new staff (if applicable). She stated these activities are to be documented in the social services progress	F 247	(4) The Quality Assurance/Performance Improvement (QAPI) team will conduct periodic audits to identify any noncompliance. Completion Date: 11-7-16	

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F 247	Continued From page 26	F 247		

notes for the resident. When shown the above-referenced note for Resident #3's move on 6/21/16, OSM #14 stated: "I did not initiate this room transfer. The admissions coordinator did. She is not here anymore. I don't know what happened. It does not look as though the resident was informed or shown the new room ahead of time." She stated that it's possible that the move occurred after business hours, but she was not certain. She stated that the process she described regarding showing the resident the new room ahead of time should have been followed.

On 10/6/16 at 1:40 p.m., ASM #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

A review of the facility policy entitled "Room Changes" revealed, in part, the following: "Prior to the room change, the team should give the resident/legal representative notice to allow the resident/legal representative time to prepare for the room change. The notice period may be waived by the resident/legal representative. Emergent conditions or safety concerns, as determined by the team, may supersede (sic) the notice period."

No further information was provided prior to exit.

(1) "An unpredictable disease of the central nervous system, multiple sclerosis (MS) can range from relatively benign to somewhat disabling to devastating, as communication between the brain and other parts of the body is disrupted. Many investigators believe MS to be an autoimmune disease – one in which the body, through its immune system, launches a defensive

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F 247	Continued From page 27 attack against its own tissues. In the case of MS, it is the nerve-insulating myelin that comes under assault. Such assaults may be linked to an unknown environmental trigger, perhaps a virus." This information is taken from the website http://www.ninds.nih.gov/disorders/multiple_sclerosis/multiple_sclerosis.htm. (2) "A contracture develops when the normally stretchy (elastic) tissues are replaced by non-stretchy (inelastic) fiber-like tissue. This tissue makes it hard to stretch the area and prevents normal movement.	F 247		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide a clean, comfortable, home-like environment for three of 32 residents in the survey sample, Residents #3, #14 and #21; and in one of 58 resident bathrooms, the bathroom between rooms 132 and 134. 1. The facility staff failed to ensure Resident #3's wheelchair armrests and a back cushion was clean and maintained in good repair. 2. The facility staff failed to provide Resident #14	F 252	F 252 (1) The armrests and back cushion for resident #3 has been replaced. The fall mat for resident # 14 was replaced. The HVAC for resident #21 is functioning and the window has been fixed. The brief was disposed of properly from bathroom between rooms 132 and 134.	

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F 252	Continued From page 28 with clean fall mats in good repair. 3. For Resident #21, the facility staff failed to provide a functioning heating/air conditioning unit and have a window in good repair. 4. Facility staff failed to ensure the resident bathroom between rooms 132 and 134 (shared bathroom) was free from a soiled brief on the floor. The findings include: 1. Resident #3 was admitted to the facility on 8/31/15, and most recently readmitted on 11/13/15, with diagnoses including, but not limited to: multiple sclerosis (1), cognitive impairment, contractures (2), and diabetes. On the most recent MDS (minimum data set), a significant change assessment with an assessment reference date of 9/4/16, he was coded as having no cognitive impairment for making daily decisions. The resident was coded as using a wheelchair for moving around his room and the unit during the look back period. On the following dates and times, Resident #3 was observed lying in bed; his motorized wheelchair was located at the foot of the bed: 10/4/16 at 4:10 p.m.; 10/5/16 at 8:30 a.m. and 10:00 a.m. Attempts to interview Resident #3 at these times were unsuccessful. Both the wheelchair armrests were covered with a lamb's wool material. The covering was matted and soiled. The coverings were secured to the arms with duct tape. The tape was chipped and peeling off in places. The back cushion was raw foam rubber with no covering. The foam rubber was soiled and worn.	F 252	(2) All residents have the potential to be affected by this deficient practice. The facility will conduct an audit of 100% of wheelchairs for armrests and cushions that need repair or replacement by the Maintenance Director or designee. 100% audit of the fall mats that need to be replaced will be conducted by the Housekeeping Supervisor or designee. 100% audit of HVAC units and windows for function and repair by the Maintenance Director or designee. 100% audit of resident bathrooms for cleanliness by the Housekeeping Supervisor or designee. Concerns identified will be promptly addressed and as appropriate, reported to the QA/I team for follow through. (3) The facility will (a) review/revise/enforce/monitor its policies & procedures ensuring maintenance and cleanliness of the facility. (b) In-service staff on the Maintenance Log and policies around maintenance of the facility (c) Staff making rounds will complete Maintenance work orders as	

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On 10/6/16 at 10:30 a.m., LPNs (licensed practical nurses) #14 and #10, and CNA (certified nursing assistant) #14, accompanied this surveyor to look at Resident #3's wheelchair. When asked to describe the armrests, LPN #14 stated: "It needs new arms." LPN #14 stated: "It is nasty looking." All three staff members agreed that the back cushion should have a cover, both for appearances and for comfort for the resident. When asked if the wheelchair looked home-like and clean, they stated that it did not. LPN #10 stated that she would notify therapy services to replace the armrest covers and the back cushion immediately.

On 10/6/16 at 1:40 p.m., ASM #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

A review of the facility policy entitled "Equipment Repairs" revealed, in part, the following: "All equipment in need of repair is returned to the vendor or manufacturer. We do not repair equipment. It is replaced."

No further information was provided prior to exit.
(1) "An unpredictable disease of the central nervous system, multiple sclerosis (MS) can range from relatively benign to somewhat disabling to devastating, as communication between the brain and other parts of the body is disrupted. Many investigators believe MS to be an autoimmune disease -- one in which the body, through its immune system, launches a defensive attack against its own tissues. In the case of MS, it is the nerve-insulating myelin that comes under assault. Such assaults may be linked to an unknown environmental trigger, perhaps a virus."

needed. Maintenance will complete items from the Maintenance log and turn into the Executive Director or designee to sign and monitor weekly for three months. Maintenance and Housekeeping staff will monitor facility audit of designated areas weekly for three months

(4) The Quality Assurance/Performance Improvement (QAPI) team will conduct periodic audits to identify any noncompliance.

Completion Date: 11-7-16

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This information is taken from the website http://www.ninds.nih.gov/disorders/multiple_sclerosis/multiple_sclerosis.htm.
(2) "A contracture develops when the normally stretchy (elastic) tissues are replaced by non-stretchy (inelastic) fiber-like tissue. This tissue makes it hard to stretch the area and prevents normal movement.

2. The facility staff failed to provide Residentt #14 with clean fall mats in good repair.

Resident #14 was admitted to the facility on 10/26/12 and most recently readmitted on 1/23/13 with diagnoses including, but not limited to: history of a stroke; COPD (chronic obstructive pulmonary disease (1)), heart disease and diabetes. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 7/27/16, he was coded as being moderately impaired for making daily decisions. He was coded as having had no falls during the look back period.

On the following dates and times, Resident #14 was observed lying in his bed. On all observations, fall mats were present on both sides of his bed: 10/4/16 at 4:30 p.m.; 10/5/16 at 7:35 a.m., 8:30 a.m., and 1:20 p.m. On all observations, the gray fall mats were dirty, chipped and contained spatters of white paint scattered all over the mats.

On 10/6/16 at 10:35 a.m., LPNs (licensed practical nurses) #10 and #14, and CNA (certified nursing assistant) #14, accompanied this surveyor to look at Resident #14's fall mats. When asked to describe the fall mats, LPN #10 stated: "They are so dirty." CNA #14 identified

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the white blotches as "old paint" and stated the mats should be changed.

On 10/6/16 at 1:40 p.m., ASM #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

(1) "COPD, or chronic obstructive pulmonary (PULL-mun-ary) disease, is a progressive disease that makes it hard to breathe. "Progressive" means the disease gets worse over time." This information is taken from the website http://www.nhlbi.nih.gov/health/health-topics/topics/copd.

3. For Resident #21, the facility staff failed to provide a functioning heating/air conditioning unit and have a window in good repair.

Resident #21 was admitted to the facility on 10/21/15 with diagnoses that included but were not limited to: high blood pressure, dementia, depression, PTSD (post-traumatic stress disorder) chronic pain, neuropathy, chronic pain, and alcohol abuse.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an

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assessment reference date of 9/20/16, coded the resident with a BIMS (brief interview for mental status) score of 10, indicating he was moderately impaired to make daily cognitive decisions. The resident was coded as requiring supervision for eating after set up assistance was provided. He required limited assistance for moving on and off the unit, and extensive assistance for bed mobility, transfers, dressing, toileting and personal hygiene.

On 10/6/16 at 8:20 a.m. observation was made of Resident #21's room. The heating/air conditioning unit under the window was observed unplugged and without control knobs. The heating/air conditioning unit was off the wall approximately one inch. When asked if his room was comfortable, Resident #21 stated, "No, I can't adjust the temperature. It blows cool air." When asked if he had told anyone, Resident #21 stated, "I told the nurses." When asked if he goes to activities, Resident #21 stated, "No, I sit here and watch the bugs crawl through the broken window."

The window was observed. The window frame was taped with aluminum duct tape down the center where the two windows meet. It was taped so the windows could not be opened. At the bottom of the right window frame, in the center where the two windows met, there was a gap of approximately one quarter of an inch where the edge of the glass was pulled away from the window frame and air was noted to come in from the outside. Four and a half dead bugs were observed on the window ledge.

On 10/6/16 at 8:33 a.m. OSM (other staff member) #1, the maintenance director, was

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shown Resident #21's room. When asked the process for identifying maintenance concerns, OSM #1 stated, "I just started in this position in July of this year. We do mock survey rounds every morning. There is a maintenance log on each unit. There is a maintenance person for each unit." When shown Resident #21's room, OSM #1 stated he was not aware of the heating/air conditioning unit being in disrepair and was not aware of the window. The maintenance log book for the unit Resident #21 resided in was reviewed with OSM #1. The only maintenance repair requested was dated, 7/21/16. The "Repair Requisition" documented, "Both cont (control) knobs on A/C (air conditioning) are missing." At the bottom of the requisition form it was documented, "Replaced both knobs with new ones." There were no further requests for maintenance for Resident #21's room. OSM #1 was asked to check the temperature of Resident #21's room. The room temperature was read as 73.5 degrees. At 8:54 a.m. maintenance was in the room to put on new knobs and secure the unit to the wall. When OSM #1 asked the resident if he wanted heat or air conditioning, Resident #21 stated, "I need the heat on, it's cold in here."

An interview was conducted with LPN (licensed practical nurse) #1, on 10/6/16 at 9:29 a.m. LPN #1 was asked how a nurse would report something that was broken or in need of repair in a resident's room. LPN #1 stated, "We have a maintenance log book and we fill in the slip. If its emergent you can call them (maintenance)." When asked if anyone can write in the maintenance book, LPN #1 stated, "Yes, anyone can write in in."

An interview was conducted with CNA (certified

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nursing assistant) #1 on 10/6/16 at 9:32 a.m. CNA #1 was asked what she does if she finds something in need of repair in a resident's room. CNA #1 stated, "I first have to ensure the resident's safety. Then either call maintenance or if not emergent, put it in the maintenance log book."

The facility policy, "Maintenance" documented in part, "The Director of Environmental Services will follow all policies regarding routine periodic maintenance. The Director of Environmental Services will perform daily rounds of the building to ensure the plant is free of hazards and in proper physical condition. All employees will report physical plant areas or equipment in need of repair or service to their supervisor. All items needing maintenance assistance will be reported to maintenance using the Maintenance Repair Request Form. The form will be completed and placed in a designated area on the nursing unit or in the maintenance office. Environmental Services personnel will check for completed forms throughout the day. The Requests will be prioritized and completed according to need. If unable to complete the request in a reasonable period of time, the originator will be notified as to the current status and further resolution."

The administrator was made aware of the above concerns on10/6/16 at 9:20 a.m.

No further information was provided prior to exit.

4. The facility staff failed to ensure the resident bathroom between rooms 132 and 134 (shared bathroom) was free from a soiled brief on the floor.

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On 10/4/16 at 1:25 p.m., tour of the facility was conducted. At 1:30 p.m., the bathroom in between rooms 132 and 134 was observed to have a soiled brief on the floor in the corner.

On 10/4/16 at 2 p.m., the soiled brief was observed on the floor in the corner of the bathroom in between rooms 132 and 134.

On 10/4/16 at 2:45 p.m., a housekeeping staff member, (OSM (Other Staff Member) #15) was in front of room 132. He was observed starting to mop the floor until he noticed the soiled brief. He alerted a CNA who worked that section to pick up the soiled brief. At 2:55 p.m., the CNA who worked that section disposed of the soiled brief.

On 10/4/16 at 2:55 p.m., an interview was conducted with OSM #15. When asked how often he rounded on resident rooms to clean, OSM #15 stated that he mops and cleans every room after breakfast and before lunch so that cleaning supplies are not on the floor when meal trays are being served. When asked who was responsible for ensuring dirty items like briefs are picked up off the floor, OSM #15 stated that if he sees items like soiled briefs, he will tell the nursing staff. OSM #15 stated that he cannot pick up soiled briefs and put them in his trash because he has to travel to every resident room with his cart. When asked if he saw the soiled brief in the bathroom in between rooms 132 and 134, OSM #15 stated that he did. OSM #15 stated that as soon as he saw the brief, he told the CNA and she picked the brief up off the floor. OSM #15 stated soiled briefs should not be on the floor due to contamination.

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On 10/4/16 at approximately 3:15 p.m., an interview was conducted with CNA (certified nursing assistant) #23. When asked how often CNAs rounded on resident rooms, CNA #23 stated that she rounds every 1-2 hours. When asked what rounding included, CNA #23 stated that it included checking on the resident to see if they are soiled, to see if they are having any unusual behaviors, making sure residents are safe, and to make sure rooms are clean. When asked if resident bathrooms are included during the rounding process to ensure they are clean, CNA #23 stated that resident bathrooms were included. When asked if soiled briefs should be left on the floor of a resident's bathroom, CNA #23 stated that soiled briefs should not be on the floor. CNA #23 stated that it was the nursing staff that is responsible for picking up soiled items like linen and briefs.

On 10/5/16 at 10:25 a.m., an interview was conducted with CNA #12, the CNA who was assigned to rooms 132 and 134 on 10/4/16. When asked how often CNAs rounded on resident rooms, CNA #12 stated that she rounded every hour and a half. When asked what rounding included, CNA #12 stated that it included changing residents or toileting them, looking to see if bed or chair alarms are in place, making sure call bells are in reach, and to see if rooms are clean. When asked if cleanliness of rooms included the resident's bathroom, CNA #12 stated that resident's bathrooms were included and were checked for trash, clutter and items on the ground. When asked if she was the CNA who picked up the dirty brief in the bathroom between rooms 132 and 134, CNA #12 stated that she was. When asked if dirty briefs should be on the floor, CNA #12 stated, "No, because of

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F 252	Continued From page 37 contamination." CNA #12 could not recall the last time she was in that bathroom but stated that they have residents who take off their briefs and throw them on the floor. On 10/5/16 at 5:11 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above findings. Facility policy titled, "Guidelines for Disposable Resident Care Items" did not address how to dispose of soiled briefs or rounding on resident rooms. No further information was presented prior to exit.	F 252		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to maintain resident rooms in good repair in eight of 98 resident rooms, (Resident rooms # 100, # 112, # 113, # 120 # 138, # 200, # 202, and # 301). The facility staff failed to maintain resident rooms # 100, # 112, # 113, # 120 # 138, # 200, # 202, and # 301 in a condition of good repair and home like environment. The findings include:	F 253	F 253, 12VAC5-371-370 (1) Ceiling tiles in rooms 100, 112 and 120 were replaced. Floor tiles in room 113 and 200 were repaired. The bottom of the door in room 202 was painted. The wall in room 138 was painted. In room 301 the wall under the sink was repaired and painted, the bottom of the wardrobe was repaired, the scrape on the wall was repaired and painted and the cable wire in the wall was covered by a wall plate.	

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Observations during the days of the survey revealed ceiling tiles with brown stains in resident rooms # 100 (five tiles), # 112 (one tile near the bathroom door), and resident room # 120 (four tiles). At the doorways to resident rooms # 113 and # 200 the floor tile was missing pieces. Resident room # 202 had paint scraped off the bottom of the room door and the door frame. In room # 138 the paint on the wall inside the door was scraped and peeling. In resident room # 301 under the sink to the left the wall is deteriorating, the cove base (baseboard) is coming off the wall, and the bottom of the wardrobe is deteriorating Continuing in resident room # 301 behind the "B" bed the paint is scraped off the wall. Next to the "A" bed there is a wire coming out of the wall (this was identified by OSM (other staff member) # 1, director of maintenance, as the cable for the television.)

On 10/6/16 beginning at approximately 9:00 a.m. an observation of resident rooms # 100, # 112, # 113, # 120 # 138, # 200, # 202, and # 301 was made with OSM # 1, OSM # 5, the director of housekeeping, and OSM #6, the area manager. OSM # 1 stated that staff do rounds every morning and then report any issues at the morning meeting. OSM # 1 stated that he was aware that there was an issue with the roof and that the stained ceiling tiles are a result. OSM # 1 stated that the facility was working on getting the roof repaired. At this time a request was made for any documentation of the roof issue. For the wire in resident room # 301 next to the "A" bed that was identified as a television cable wire, OSM # 1 stated that the resident had pulled it out of the wall and that he (OSM # 1) would have his staff push it back into the wall and put a wall plate

(2) All residents have the potential to be affected by inadequate facility maintenance. The facility will complete a 100% audit of all rooms to identify needed repairs. Any deficiencies will be addressed immediately.

(3) ED/designee will educate maintenance team and other management staff on the facility policies & procedures ensuring maintenance of the facility. ED will make weekly rounds x 3months with the maintenance director to ensure facility is clean and equipment is functional. The maintenance log will be reviewed 5x weekly for 1 month to ensure

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F 253	Continued From page 39 over it. OSM # 1 was also at this time asked for any work orders for any of the items identified in the resident rooms. OSM # 1 was asked for the facility policy on maintenance repairs. A request was also made for any documentation that OSM # 1 wanted to present. During an interview on 10/5/16 at 11:25 a.m. with LPN (licensed practical nurse) # 2, LPN # 2 was asked how maintenance issues are communicated to the maintenance staff. LPN # 2 stated that if there are any issues with items that need to be repaired one can just grab one of the maintenance crew when one sees them in the hallway. LPN # 2 further stated that the maintenance department is very responsive to requests and to getting repairs completed. During an interview on 10/5/16 at 2:30 p.m. with CNA (certified nurse's assistant) # 2, CNA # 2 was asked how maintenance issues are communicated to the maintenance staff. CNA # 2 stated that staff can just page maintenance and they come and take care of the issues; CNA # 2 further stated that staff can write the issue in the communication book - that way when maintenance comes to the unit if they cannot find you they can just look in the book. CNA # 2 stated the maintenance staff is excellent. During an interview on 10/6/16 at 8:25 a.m. with LPN # 1, LPN # 1 was asked how maintenance issues are communicated to the maintenance staff. LPN # 1 stated that there is a log book and also staff can call the maintenance department but staff should always put the request in the log book too. LPN # 1 stated that maintenance is very good about getting any requests completed.	F 253	compliance with repairs and then weekly x 1 3 months. (4) The Quality Assurance/Performance Improvement (QAPI) team will conduct periodic audits to identify any noncompliance. Completion Date: 11-7-16	

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During an interview on 10/6/16 at 10:10 a.m., ASM (administrative staff member) # 1, the administrator, was made aware of these observations and a request for any policies was made at this time. An opportunity was given to present any documentation that was available.

Review of the facility "Maintenance" policy presented by ASM # 4, Regional director, on 10/6/16 at 1:10 p.m. documented the following: under "Policy" "The facility's physical plant and equipment will be maintained through a program of preventive maintenance and prompt action to identify areas/items in need of repair." Under "Procedure: The Director of Environmental Services will follow all policies regarding routine periodic maintenance. The Director of Environmental Services will perform daily rounds of the building to ensure the plant is free of hazards and in proper physical condition. All employees will report physical plant areas or equipment in need of repair or service to their supervisor. All items needing maintenance assistance will be reported to maintenance using the Maintenance Repair Request form (Attachment A). The form will be completed and placed in a designated area on the nursing unit or in the maintenance office. Environmental Services personnel will check for completed forms throughout the day. The Requests will be prioritized and completed according to need. If unable to complete the request in a reasonable period of time, the originator will be notified as to the current status and further resolution."

No further information was provided by the end of the survey.

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F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review , clinical record review and in the course of complaint investigation, it was determined that the facility failed to maintain a complete and accurate MDS (minimum data set) assessment for one of 32 residents in the survey sample,

F278
(1)Resident #1 has been interviewed by Social Work.

(2)All residents within the facility have the potential to be affected by failure to complete MDS assessments completely.

(3) The facility's Policies and Procedures related to the appropriate completion of the MDS processes will be reviewed relative to the RAI manual. Appropriate staff will be educated regarding said Policies/Procedures and the importance of compliance. MDS coordinator will conduct audits weekly X 3 months to ensure MDS assessments are complete
4. Compliance will be monitored via the Quality Assurance Performance Improvement (QAPI) process. Results will be reported at the monthly QAPI meeting as appropriate.

Completion Date: 11-7-16

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Resident #1.

The facility staff failed to attempt an interview with Resident #1 to complete Section C, Cognitive Patterns, on Resident #1's quarterly assessment with an ARD (assessment reference date) of 7/27/16.

The findings include:

Resident #1 was admitted to the facility on 10/29/15 with diagnoses that included, but were not limited to; cerebral infarction (injury to the brain), aphasia (difficulty speaking), dysphagia (difficulty swallowing) and asthma (a disease of the lungs).

The most recent MDS assessment was a significant change assessment with an ARD of 8/19/16. On the Brief Interview for Mental Status (BIMS) in Section C, Cognitive Patterns. Resident #1 was coded as a three out of a possible 10 indicating that Resident #1 was significantly impaired with cognitive skills for daily decision making. Section B, Hearing, Speech and Vision, coded Resident #1 as sometimes understood and usually understands.

Section C of Resident #1's quarterly MDS with an ARD of 7/27/16 documented, "C0100. Should Brief Interview for Mental Status be Conducted? - Attempt to conduct interview with all residents." A "0" was entered indicating that resident was unable to complete an interview. A staff assessment was conducted and completed. Section B, Hearing, Speech and Vision, coded Resident #1 as sometimes understood and usually understands.

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On 10/4/16 at 4:15 p.m. Resident #1 was observed lying in her bed, watching the television. When this surveyor entered Resident #1's room she smiled and when asked how she was Resident #1 did not speak but did put a thumbs up, indicating all was well.

On 10/5/16 at approximately 11:00 a.m. an interview was conducted with OSM (other staff member) #14, the social worker. OSM #14 was asked to state the sections of the MDS that she was responsible for completing. OSM #14 stated that she was responsible to complete Sections C, D, E and Q. OSM #14 was asked whether or not she interviewed the residents to complete any of those sections. OSM #14 stated, "I do resident interviews for Sections C and D." OSM #14 was asked whether or not there were any situations that would prevent her from attempting to interview a resident for those sections. OSM #14 Stated, "We always attempt to conduct an interview, if the resident is nonverbal then we move to the staff assessment." OSM #14 was asked under what circumstances an interview would not be attempted to complete Sections C and D. OSM #14 stated, "We would not attempt an interview if the resident was in a vegetative stated." OSM #14 was shown Schedule C of Resident #1's MDS assessment with an ARD of 7/27/16 and asked whether or not an interview was attempted on Resident #1. OSM #14 stated, "I did not do that MDS assessment but an interview should have been attempted, the coding is incorrect, the response should have been "1" (one) and then we could move to the staff assessment." OSM #14 was asked what she used as a reference guide to complete the MDS sections that she was responsible for. OSM #14 stated, "I refer to the RAI (resident assessment

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F 278	Continued From page 44 instrument) to complete my MDS sections." An end of date meeting was conducted on 10/5/16 at 5:15 p.m. with ASM (administrative staff member) #1, the administrator, and ASM #4, the regional director of nursing services. ASM #1 and ASM #2 were made aware of the above findings. No further information was provided prior to the end of the survey.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for one of 32 residents in the survey sample, Resident #3. The facility staff signed off physician-ordered knee braces as though the orders were followed for Resident #3 on 10/5/16. Observation revealed that the braces were never applied that day. The findings include: Resident #3 was admitted to the facility on 8/31/15, and most recently readmitted on 11/13/15, with diagnoses including, but not limited	F281	1. Resident #3 is wearing knee braces as tolerated per MD order. 2. Residents with orders for assistive devices have the potential to be affected. DCS conducted observations of residents with assistive devices and none were found to be out of compliance with MD order. 3. Staff education has been provided to staff on following MD orders. Weekly audits to be conducted on following md orders for assistive devices x3 months to ensure compliance. 4. Director of Clinical Services /designee will report results of audits to the Quality Assurance/Performance Improvement (QAPI) monthly for review and recommendations Completion Date: 11-7-16	

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to: multiple sclerosis (1), cognitive impairment, contractures (2), and diabetes. On the most recent MDS (minimum data set), a significant change assessment with an assessment reference date of 9/4/16, Resident #3 was coded as having no cognitive impairment for making daily decisions. He was coded as being functionally limited in range of motion on both sides of his lower extremities (legs), and as having received restorative nursing services for passive range of motion and bed mobility during the look back period.

On 10/5/16 at 8:30 a.m., 10:00 a.m. and 1:30 p.m., Resident #3 was observed lying in bed; he did not have a knee braces applied. Both of Resident #3's knees were bent, and his lower legs were pulled up close to his upper legs in contractures Attempts to interview Resident #3 at these times were unsuccessful.

A review of the physician order sheet for Resident #3 revealed the following order, most recently signed by the physician on 9/27/16: "Patient to wear knee brace to both knees daily from 8am (8:00 a.m.) to at 2:00 p.m. (sic) - Please check skin before applying and after removing brace."

A review of the TAR (treatment administration record) for Resident #3 revealed nurses' initials in the boxes indicating the knee braces were applied and removed as ordered on 10/5/16.

A review of the comprehensive care plan for Resident #3 dated 9/16/16 and most recently updated on 9/22/16 revealed, in part, the following: "Bilateral knee braces as ordered."

On 10/6/16 at 10:10 a.m., LPN (licensed practical

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nurse) #10 was interviewed. She stated that Resident #3 refused to have the knee braces applied earlier that morning (10/6/16). When asked if Resident #3 frequently refuses the knee braces, LPN #10 stated: "He is more likely to refuse them if he is not up in his wheelchair." When asked if the resident's refusals should be documented, LPN #10 stated: "Yes. It should be circled on the TAR and documented in the nurses notes or the back of the TAR." When shown the TAR for 10/5/16, LPN #10 stated: "It looks like the braces were put on and taken off like the order says to do." When informed of the surveyor's observations on 10/5/16, LPN #10 stated: "You should not ever sign off that something was done if you don't know for sure it was done, or if you know for sure it wasn't done." When asked why Resident #3 has the knee braces ordered, LPN #10 stated: "He has really bad contractures. The braces help keep them from getting worse."

On 10/6/16 at 10:35 a.m., CNA (certified nursing assistant) #14 was interviewed. She stated that she is the aide who provides restorative nursing services to residents, including Resident #3. She stated that she never applies the knee braces. She stated she was not even aware that Resident #3 had an order to wear knee braces. She stated she occasionally works with the resident on passive range of motion and bed mobility. She stated she did not recall a time when Resident #3 had been wearing knee braces.

On 10/6/16 at 1:40 p.m., ASM #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

A review of the facility policy entitled "Physician

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Orders" revealed no information related to accurate nursing documentation in following physicians' orders.

No further information was provided prior to exit.
(1) "An unpredictable disease of the central nervous system, multiple sclerosis (MS) can range from relatively benign to somewhat disabling to devastating, as communication between the brain and other parts of the body is disrupted. Many investigators believe MS to be an autoimmune disease -- one in which the body, through its immune system, launches a defensive attack against its own tissues. In the case of MS, it is the nerve-insulating myelin that comes under assault. Such assaults may be linked to an unknown environmental trigger, perhaps a virus." This information is taken from the website http://www.ninds.nih.gov/disorders/multiple_sclerosis/multiple_sclerosis.htm.
(2) "A contracture develops when the normally stretchy (elastic) tissues are replaced by non-stretchy (inelastic) fiber-like tissue. This tissue makes it hard to stretch the area and prevents normal movement.

The following quotation is found in Potter and Perry's Fundamentals of Nursing, 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients."

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	905 THOMPSON STREET ASHLAND, VA 23005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that facility staff failed to follow the written plan of care for three of 32 residents in the survey sample, Resident #'s 11, 13, and 3. 1. The facility staff failed to follow the care plan and administer antibiotics per physician's order for Resident #11 on 9/28/16 through 9/30/16, 3-11 shift. 2a. The facility staff failed to provide bilateral (right and left) hand splints as documented in the comprehensive care plan for Resident # 13. b. Facility staff failed to position the adaptive call bell, a Breathcall Cord (1) within reach as documented in the comprehensive care plan for Resident # 13. 3. The facility staff failed to apply knee braces to Resident #3's bilateral knees per the comprehensive care plan and physician orders. The findings include: 1. Resident #11 was admitted to the facility on 7/15/15 with diagnoses that included but were not	F 282	F 282 1. Resident #11 did not have any adverse affects due to missed medication doses. Resident #13 is wearing hand splints as ordered and documentation is accurate. Resident #13 call bell is positioned properly within reach. Resident #3 is wearing knee braces as tolerated per MD order and documentation is accurate. 2. Residents that reside in the facility have the potential to be affected by failure to follow Physician orders and failure to have call bell access. DCS reviewed Physician orders written over past 30 days and interviewed residents and none reported not receiving medications. Observations were made and found that devices were applied as ordered by Physician and call bells were observed to be within reach.	

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ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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resident was medicated with as needed oxycodone per physician's orders from 8/12/16 through 8/22/16. The back of the MAR documented the medication was effective.

A physician's order dated 8/22/16 documented an order to discontinue MS Contin and change the oxycodone order to scheduled oxycodone 10 mg every four hours.

A physician's note dated 8/25/16 documented, "Few days ago, he was having issues with his pain medications. MS Contin was discontinued and his oxycodone was scheduled to routine rather than p.r.n. and has helped his symptoms..."

On 10/6/16 at 11:10 a.m., a telephone interview was conducted with OSM (other staff member) #16 (pharmacist). OSM #16 was asked if the pharmacy received any prescriptions for Resident #23's MS Contin. OSM #16 stated she needed to review the notes in the pharmacy computer system. OSM #16 stated the pharmacy did receive a prescription for Resident #23's MS Contin but the prescription had to be clarified and was clarified on 8/12/16. OSM #16 stated the physician ordered generic MS Contin but Resident #23's insurance plan preferred the brand name medication Kadian; therefore, the resident's physician would have needed to complete a prior authorization for the medication. OSM #16 stated it didn't look like the prior authorization was completed.

On 10/6/16 at 1:00 p.m., ASM (administrative staff member) #2 (the director of nursing) was made aware of the above findings. This surveyor requested to speak to Resident #23's physician to

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obtain clarification as to why the physician didn't address the insurance concern regarding the resident's MS Contin when notified on 8/14/16 (per the nurse's note) and why the pain medication wasn't addressed until 8/22/16 when the resident's MS Contin was discontinued and oxycodone was scheduled. ASM #2 stated Resident #23's physician was out of the country during that time period and she (ASM #2) couldn't identify which physician the nurse spoke to on 8/14/16. ASM #2 stated she would contact Resident #23's physician.

On 10/6/16 at 2:25 p.m., a telephone interview was conducted with ASM (administrative staff member) #5 (Resident #23's physician). ASM #5 was made aware of the above findings. ASM #5 stated he wanted to put Resident #23 on long acting pain medication and insurance wouldn't pay for that type of medication but the resident was already receiving as needed oxycodone. ASM #5 stated, "If insurance doesn't pay what can we do?" ASM #5 was asked if he received a prior authorization regarding the resident's MS Contin. ASM #5 stated he couldn't remember if he filled one out. ASM #5 stated the resident wanted pain medication that wasn't covered by insurance so he (ASM #5) had to cancel the MS Contin order and schedule oxycodone. When asked why this wasn't addressed or done between 8/14/16 and 8/22/16, ASM #5 stated, "I don't know. I don't know what to say."

On 10/6/16 at 2:26 p.m., ASM #2 was made aware of the above findings.

On 10/6/16 at 3:18 p.m., another interview was conducted with ASM #5 ASM #5 stated he wanted to put Resident #23 on long term pain

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F 385	Continued From page 101 medication but the resident's insurance didn't cover that type of medication. ASM #5 stated Fentanyl made the resident too sleepy and insurance didn't cover other long term pain medications so the resident was switched to oxycodone. No further information was presented prior to exit. (1) MS Contin is indicated for the management of severe pain. This information was obtained form the website: https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=E0472C35-3F44-42E2-9B75-37B2E9FF65F6 (2) Oxycodone is used to treat pain. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=5999f3c3-3225-4d24-82cd-0b8d7a309587 (3) Quadriplegia is paralysis of the arms and legs. This information was obtained from the website: https://medlineplus.gov/paralysis.html (4) Fentanyl patch is used to treat chronic pain. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=9baf2912-9d0f-412a-8fbf-617f6a4f91ed	F 385		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all	F 431	1. All controlled drugs are stored behind double locks on 3/3 units in the facility. 2. No residents were affected by this deficient practice.	

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F 431	Continued From page 102 controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to store controlled substances safely in two of three medication rooms, the medication rooms on the 100 and 200 hallways. The facility staff failed to store Lorazepam (1) and Marinol (2) behind double locks in the 100 hallway medication room.	F 431	3. Staff has been educated on maintaining controlled drugs behind double locked procedure. Audits to be conducted daily x1 month and then weekly x2 months of locked controlled drug storage system to ensure compliance. 4. Director of Clinical Services /designee will report results of audits to the Quality Assurance/Performance Improvement (QAPI) monthly for review and recommendations Completion Date: 11-7-16	

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The facility staff failed to store Lorazepam behind double locks in the 200 hallway medication room.

The findings include:

On 10/6/16 at 11:55 a.m., observation was made of the medication room on the 100 hallway. LPN (licensed practical nurse) #1, the unit manager, accompanied the surveyor on the observation. LPN #1 unlocked the medication room. When the surveyor asked LPN #1 to unlock the medication refrigerator, LPN #1 was able to open the refrigerator without unlocking it. She opened an unlocked drawer and showed the surveyor six 0.25 ml (milliliter) syringes of Lorazepam and 118 Marinol tablets (2.5 mgs [milligrams] each). When asked if the Marinol and Lorazepam are considered to be controlled substances, LPN #1 stated: "Yes they are." When asked how these medications are to be secured, LPN #1 stated: "They should be behind two locks. I'm not sure what happened here."

On 10/6/16 at 12:05 p.m., observation was made of the medication room on the 200 hallway. LPN #3 accompanied the surveyor on the observation. LPN #3 unlocked the door to the medication room. When the surveyor asked to see the narcotics in the refrigerator, LPN #3 opened the unlocked refrigerator and showed the surveyor four bottles of Lorazepam Intensol. The bottles had the following amounts remaining: 25 mls, 18 mls, 30 mls and 30 mls. LPN #3 was asked if Lorazepam is considered a controlled substance. She stated: "Yes." When asked how controlled substances are to be secured, she stated: "They are supposed to be locked."

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On 10/6/16 at 1:40 p.m., ASM #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

A review of the facility policy entitled "Storage and Expiration of Medications, Biologicals, Syringes and Needles" revealed, in part, the following: "Facility should ensure that Schedule II - V controlled substances are only accessible to licensed nursing, pharmacy and medical personnel designated by facility. After receiving controlled substances and adding to inventory, facility should ensure that Schedule II - V controlled substances are immediately placed into a secured storage area...in all cases in accordance with Applicable Law...Facility should store Schedule II controlled substances and other medications deemed by facility to be at risk for abuse or diversion in a separate compartment within the locked medication carts and should have a different key or access device."

No further information was provided prior to exit.

(1) "Lorazepam is used to relieve anxiety. Lorazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow for relaxation." This information is taken from the National Institutes of Health website <https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682053.html>.

(2) "Dronabinol (Marinol) is used to treat nausea and vomiting caused by chemotherapy in people who have already taken other medications to treat this type of nausea and vomiting without good results. Dronabinol is also used to treat loss of appetite and weight loss in people who have

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F 431	Continued From page 105 acquired immunodeficiency syndrome (AIDS). Dronabinol is in a class of medications called cannabinoids. It works by affecting the area of the brain that controls nausea, vomiting, and appetite." This information is taken from the website https://medlineplus.gov/druginfo/meds/a607054.html. "Dronabinol is a Schedule 3 medication ...Has a potential for abuse less than those in schedules 1 and 2. Has a currently accepted medical use in treatment in the United States. Abuse may lead to moderate or low physical dependence or high psychological dependence." This information is taken from the website https://www.drugs.com/pro/marinol.html.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441	F441 (1)Facility infection control log is complete and current. Resident #3 has a new and clean wheelchair cushion and armrest. Resident #14 has clean fall mats in place. Bathroom between rooms 132 and 134 is free from soiled briefs and odor.	

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F 441	Continued From page 106 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to maintain an effective infection control program as evidenced by incomplete monthly infection logs from January 2016 through August 2016; and failed to implement infection control practices for two of 32 residents in the survey sample, (Residents #3 and #14); and failed maintain a resident bathroom in a clean manner to prevent the spread of infection (resident bathroom between rooms 132 and 134). 1. The facility staff failed to have complete infection control logs. The infection logs from January 2016 through August 2016 were incomplete.	F 441	(2) Residents that reside in the facility have the potential to be affected by poor infection control practices. DCS has conducted wheelchair inspections and found none to be dirty or in poor condition. Fall mats have been inspected by DCS and none have been found dirty. Bathrooms have been inspected by DCS and no soiled briefs were noted. (3)Staff education will be provided on infection handwashing to staff. Weekly audits of the Infection control log will be done x3 months. Audits will be conducted weeklyx3month of wheelchairs. Audits will be conducted weeklyx3months of fall mats. Audits will be conducted twice a week and then once a week x2 months of bathrooms in the facility. (4) The Quality Assurance/Performance Improvement (QAPI) team will conduct periodic audits to identify any noncompliance. Completion Date: 11-7-16	

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2. The facility staff failed to provide wheelchair armrests and cushions in good repair, allowing them to be cleaned to prevent transmission of infection for Resident #3.

3. The facility staff failed to provide fall mats in good repair, allowing them to be cleaned to prevent transmission of infection for Resident #14.

4. Facility staff failed to ensure the resident bathroom between rooms 132 and 134 was free from a soiled brief on the floor causing contamination.

The findings include:

1. The facility staff failed to maintain a complete infection control program.

The review of the monthly facility infection logs from January 2016 through August 2016 was conducted. The following was documented:
January 2016: 45 infections were documented, only four of them had the "site" of the infection documented. There were only two results of cultures documented. The column for "isolation - Yes/No" was blank, none recorded.
February 2016: 38 infections were documented. Only four had the "site" of the infection documented. There were only four results of cultures documented. The column for "isolation - Yes/No" was documented for four infections, the others were blank.
March 2016: 41 infections were documented. Fourteen had the "site" of the infection documented. There were no culture results

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documented. Two residents were documented as having been placed on isolation. The other spaces were blank.
April 2016: 29 infections were documented. Ten had the "site" of the infection documented. There was one documented organism. There were sixteen columns checked if a resident was placed on isolation or not on isolation, the others were blank.
May 2016: 33 infections were documented. Seventeen had the "site" of the infection documented. There was one documented organism. There were 11 blanks as to if a resident was placed on isolation or not on isolation, the others were blank.
June 2016: 16 infections were documented. One failed to document the "site" of the infection. There were four documented organisms. There was no documentation in the column for if a resident was placed on isolation or not on isolation, the others were blank.
July 2016: 40 infections were documented. Eleven documented the "site" of the infection. Only three organisms were documented. There were 18 documented in the column for if a resident was placed on isolation or not on isolation, the others were blank.
August 2016: 49 infections were documented. One had the documented "site" of the infection. There were no organisms documented. There were 15 documented in the column for if a resident was placed on isolation or not on isolation, the others were blank.

An interview was conducted with administrative staff member (ASM) #2, the director of nursing; on 10/6/16 at 11:10 a.m. ASM #2 reviewed the tracking logs with this surveyor. When asked if the site of an infection should be documented on

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the tracking logs, ASM #2 stated, "Yes." When asked if a culture was obtained, should that information be on the tracking forms, ASM #2 stated, "Yes." When asked if the organism should be completed on the form if a culture was done, ASM #2 stated, "Yes." When asked who completes these tracking logs, ASM #2 stated, "I just took over them two weeks ago. The person who did them previously is no longer employed here." When asked the purpose of tracking infections in the building, ASM #2 stated, "It's to track and trend areas as to what education is needed if we see a rise in a certain type of infection."

The facility policy, "Infection Control Surveillance" documented, "The infection Control Committee is responsible for overseeing the Infection Control Surveillance monitoring and evaluation process. Important aspects of care are identified and surveillance indicators are chosen. Indicator data is collected, analyzed and reported to the Infection Control Committee and the Performance Improvement Committee...Procedure: 1. The Infection Control Committee (ICC) directs the infection control program and maintains minutes of all activities. The scope of surveillance includes: a. establishing baseline Nosocomial infection rates. b. Review of microbiological reports. c. Review of resident infections to determine whether an infection is nosocomial, using the CDC (Center for Disease Control) guidelines. d. Review and analysis of surveillance data to include: i. Infections due to unusual pathogens. ii. Clusters of infections. iii. Unusual epidemics. iv. Nosocomial infection rate exceeds the baseline. v. Infections, populations or policies which are: a. high risk. b. High volume. c. Problem prone."

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5 COMPLE DAT
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The administrator was made aware of the above findings on 10/6/16 at 11:44 a.m.

No further information was provided prior to exit.

2. The facility staff failed to provide wheelchair armrests and cushions in good repair, allowing them to be cleaned to prevent transmission of infection for Resident #3.

Resident #3 was admitted to the facility on 8/31/15, and most recently readmitted on 11/13/15, with diagnoses including, but not limited to: multiple sclerosis (1), cognitive impairment, contractures (2), and diabetes. On the most recent MDS (minimum data set), a significant change assessment with an assessment reference date of 9/4/16, he was coded as having no cognitive impairment for making daily decisions. The resident was coded as using a wheelchair for moving around his room and the unit during the look back period.

On the following dates and times, Resident #3 was observed lying in bed; his motorized wheelchair was located at the foot of the bed: 10/4/16 at 4:10 p.m.; 10/5/16 at 8:30 a.m. and 10:00 a.m. Attempts to interview Resident #3 at these times were unsuccessful. Both the wheelchair armrests were covered with a lamb's wool material. The covering was matted and soiled. The coverings were secured to the arms with duct tape. The tape was chipped and peeling off in places. The back cushion was raw

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NAME OF PROVIOER OR SUPPLIER	STREET ADORESS, CITY, STATE, ZIP COOE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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foam rubber with no covering. The foam rubber was soiled and worn.

On 10/6/16 at 10:30 a.m., LPNs (licensed practical nurses) #14 and #10, and CNA (certified nursing assistant) #14, accompanied the surveyor to look at Resident #3's wheelchair. When asked to describe the armrests, LPN #14 stated: "It needs new arms." LPN #14 stated: "It is nasty looking." All three staff members agreed that the back cushion should have a cover, both for appearances and for comfort for the resident. When asked if the armrests and back cushion could be cleaned, all three staff members said they could not. When asked why this was important, LPN #10 stated: "For infection control." LPN #10 stated that she would notify therapy services to replace the armrest covers and the back cushion immediately.

On 10/6/16 at 1:40 p.m., ASM #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

A review of the facility policy entitled "Equipment Repairs" revealed, in part, the following: "All equipment in need of repair is returned to the vendor or manufacturer. We do not repair equipment. It is replaced."

No further information was provided prior to exit.

(1) "An unpredictable disease of the central nervous system, multiple sclerosis (MS) can range from relatively benign to somewhat disabling to devastating, as communication between the brain and other parts of the body is disrupted. Many investigators believe MS to be an autoimmune disease -- one in which the body, through its immune system, launches a defensive

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ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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attack against its own tissues. In the case of MS, it is the nerve-insulating myelin that comes under assault. Such assaults may be linked to an unknown environmental trigger, perhaps a virus." This information is taken from the website http://www.ninds.nih.gov/disorders/multiple_sclerosis/multiple_sclerosis.htm.
(2) "A contracture develops when the normally stretchy (elastic) tissues are replaced by non-stretchy (inelastic) fiber-like tissue. This tissue makes it hard to stretch the area and prevents normal movement.

3. The facility staff failed to provide fall mats in good repair, allowing them to be cleaned to prevent transmission of infection for Resident #14.

Resident #14 was admitted to the facility on 10/26/12 and most recently readmitted on 1/23/13 with diagnoses including, but not limited to: history of a stroke; COPD (chronic obstructive pulmonary disease((1), heart disease and diabetes. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 7/27/16, he was coded as being moderately impaired for making daily decisions. He was coded as having had no falls during the look back period.

On the following dates and times, Resident #14 was observed lying in his bed. On all observations, fall mats were present on both sides of his bed: 10/4/16 at 4:30 p.m.; 10/5/16 at 7:35 a.m., 8:30 a.m., and 1:20 p.m. On all observations, the grey fall mats were dirty, chipped and contained spatters of white paint scattered all over the mats.

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On 10/6/16 at 10:35 a.m., LPNs (licensed practical nurses) #14 and #10, and CNA (certified nursing assistant) #14, accompanied the surveyor to look at Resident #3's wheelchair. When asked to describe the fall mats, LPN #10 stated: "They are so dirty." CNA #14 identified the white blotches as "old paint" and stated the mats should be changed. When asked why it would be important for the mats to be cleaned, LPN #10 stated: "For infection control."

On 10/6/16 at 1:40 p.m., ASM #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

(1) "COPD, or chronic obstructive pulmonary (PULL-mun-ary) disease, is a progressive disease that makes it hard to breathe. "Progressive" means the disease gets worse over time." This information is taken from the website http://www.nhlbi.nih.gov/health/health-topics/topics/copd.

4. The facility staff failed to ensure the resident bathroom between rooms 132 and 134 was free from a soiled brief on the floor causing contamination.

On 10/4/16 at 1:25 p.m., tour of the facility was conducted. At 1:30 p.m., the bathroom in-between rooms 132 and 134 were observed to have a soiled brief on the floor in the corner.

On 10/4/16 at 2 p.m., the soiled brief was observed on the floor in the corner of the bathroom in-between rooms 132 and 134.

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On 10/4/16 at 2:45 p.m., a housekeeping staff member (OSM (Other Staff Member) #15) was in front of room 132. He was observed to start mopping the floor until he noticed the soiled brief. He alerted a CNA who worked that section to pick up the soiled brief. At 2:55 p.m., the CNA who worked that section disposed of the soiled brief.

On 10/4/16 at 2:55 p.m., an interview was conducted with OSM #15. When asked how often he rounded on resident rooms to clean, OSM #15 stated that he mops and cleans every room after breakfast and before lunch so that cleaning supplies are not on the floor when meal trays are being served. When asked who was responsible for ensuring dirty items like briefs are picked up off the floor, OSM #15 stated that if he sees items like soiled briefs, he will tell the nursing staff. OSM #15 stated that he cannot pick up soiled briefs and put them in his trash because he has to travel to every resident room with his cart. When asked if he saw the soiled brief in the bathroom in-between rooms 132 and 134, OSM #15 stated that he did. OSM #15 stated that as soon as he saw the brief, he had told the CNA and she picked the brief up off the floor. OSM #15 stated soiled briefs should not be on the floor due to contamination.

On 10/4/16 at approximately 3:15 p.m., an interview was conducted with CNA (certified nursing assistant) #23. When asked how often CNAs rounded on resident rooms, CNA #23 stated that she rounds every 1-2 hours. When asked what rounding included, CNA #23 stated that it included checking on the resident to see if they are soiled, to see if they are having any unusual behaviors, making sure residents are

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safe, and to make sure rooms are clean. When asked if resident bathrooms are included during the rounding process to ensure they are clean, CNA #23 stated that resident bathrooms were included. When asked if soiled briefs should be left on the floor of a resident's bathroom, CNA #23 stated that soiled briefs should not be on the floor. CNA #23 stated that it was the nursing staff that was responsible for picking up soiled items like linen and briefs.

On 10/5/16 at 10:25 a.m., an interview was conducted with CNA #12, the CNA who was assigned to rooms 132 and 134 on 10/4/16. When asked how often CNA's rounded on resident rooms, CNA #12 stated that she rounded every hour and a half. When asked what rounding included, CNA #12 stated that it included changing residents or toileting them, looking to see if bed or chair alarms are in place, making sure call bells are in reach, and to see if rooms are clean. When asked if cleanliness of rooms included the resident's bathroom, CNA #12 stated that resident's bathrooms were included and were checked for trash, clutter and items on the ground. When asked if she was the CNA who picked up the dirty brief in the bathroom between rooms 132 and 134, CNA #12 stated that she was. When asked if dirty briefs should be on the floor, CNA #12 stated, "No, because of contamination." CNA #12 could not recall the last time she was in that bathroom but stated that they have residents who take off their briefs and throw them on the floor.

On 10/5/16 at 5:11 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above findings.

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F 441	Continued From page 116 No policy could be provided regarding the above concern. No further information was presented prior to exit.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to maintain a functional, safe, sanitary, and comfortable environment on three of three units, (Unit #1, Unit #2 and Unit#3). The facility staff failed to maintain common areas on all three of the facility units. The findings include: Observations during the days of the survey on Unit # 1 revealed the following: The wall across from resident room 125 was observed to be caved in above the cove base (baseboard). The carpet on the wall across from resident room # 122 was coming off the wall. There were brown stains on the ceiling tiles (three) around the nurses' station and the cove base at the one entrance to the nurses' station near resident room # 105 had a damaged corner and cove base missing. The unit ice machine located across the	F 465	F465, 12VAC5-371-370 (1) On Unit#1 wall across from 125 was repaired, carpet on wall across from 122 was repaired, ceiling tiles above nurses station replaced, cove base at entrance of nurses station and 105 were replaced, ice machine room and shower room were cleaned. On Unit #2 the carpet between 213 and 215 was repaired, ceiling tiles near the nourishment room were replaced, the ice machine and shower rooms were cleaned. On Unit #3 ceiling tiles outside of room 327 were replaced. Handrails throughout the facility were repaired. (2) All residents have the potential to be affected by deficient facility maintenance.	

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F 465	Continued From page 117 hall from resident room # 120 was observed to have gloves and what appeared to be white paper towels on the floor in the back right hand corner. The unit shower room was observed to have an unflushed toilet, two adhesive bandages on the floors of two showers and a piece of gauze and tape on the floor of one shower. Observations during the days of the survey on Unit # 2 revealed the following: The carpet on the wall between resident rooms # 213 and 215 was coming off the wall. There were brown stains on the ceiling tiles outside the nourishment room and around the air return vent on the ceiling. The air return vent was dusty. The unit ice machine located across the hall from resident room # 228 was observed to have gloves on the floor in the back left hand corner. The unit shower room was observed to have one shower drain clogged with hair and near a shower bed there was a blue disposable razor on the floor. Observations during the days of the survey on Unit # 3 revealed the following brown stained ceiling tile outside resident room # 327. Observation during the days of the survey revealed that handrails on all three units on both the right and left side of the halls were found to be in poor condition. This was characterized by chipped and peeling paint and small gouges revealing a semi-rough surface. On 10/6/16 at beginning at approximately 9:00 a.m. an observation of all three units was made with OSM (other staff member) # 1, the director of maintenance, OSM # 5, the director of housekeeping, and OSM #6, the area manager. OSM # 1 stated that staff do rounds every	F 465	(3) The facility will (a) review its policies & procedures ensuring maintenance and cleanliness of the facility. (b) In-service maintenance department and other management staff on policy (c) Staff making rounds will complete Maintenance work orders as needed. Maintenance will complete items from the Maintenance log and turn into the Executive Director or designee to sign and monitor weekly for three months. Maintenance and Housekeeping staff will monitor facility audit of designated areas weekly for three months (4) The Quality Assurance/Performance Improvement (QAPI) team will conduct periodic audits to identify any noncompliance. Completion Date: 11-7-16	

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F 465	Continued From page 118 morning and then report any issues at the morning meeting. . OSM # 1 stated that he was aware that there was an issue with the roof and that the stained ceiling tiles are a result. OSM # 1 stated that the facility was working on getting the roof repaired. At this time a request was made for any documentation of the roof issue. OSM # 1 was also at this time asked for any work orders for any of the items identified on this tour. When the condition of the ice machine floor on Unit # 2 was observed OSM # 5 removed the gloves. While the observation was ongoing in the shower room on Unit # 1, OSM # 5 flushed the unflushed the toilet. OSM # 1 and OSM # 5 were asked for the facility policy on maintenance repairs and housekeeping services. A request was also made for any documentation that either OSM # 1 or OSM # 5 wanted to present. During an interview on 10/616 at 10:35 a.m. OSM # 5 presented facility policies for cleaning the shower rooms and stated that housekeeping staff was unable to get into the shower rooms because of resident showers ongoing the day before. OSM # 5 offered no explanation for the gloves and trash near the ice machines. At this time another policy was requested for cleaning the floors around the ice machines. This policy was presented by OSM # 5 on 10/6/16 at 11:45 a.m. During an interview on 10/5/16 at 11:25 a.m. with LPN (licensed practical nurse) # 2, LPN # 2 was asked how maintenance issues are communicated to the maintenance staff. LPN # 2 stated that if there are any issues with items that need to be repaired one can just grab one of the maintenance crew when one sees them in the hallway. LPN # 2 further stated that the maintenance department is very responsive to	F 465		

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requests and to getting repairs completed.

During an interview on 10/5/16 at 2:30 p.m. with CNA (certified nurse's assistant) # 2, CNA # 2 was asked how maintenance issues are communicated to the maintenance staff. CNA # 2 stated that one can just page maintenance and they come and take care of the issues; CNA # 2 further stated that one can write the issue in the communication book - that way when maintenance comes to the unit if they cannot find you they can just look in the book. CNA # 2 stated the maintenance staff is excellent.

During an interview on 10/6/16 at 8:25 a.m. with LPN # 1, LPN # 1 was asked how maintenance issues are communicated to the maintenance staff. LPN # 1 stated that there is a log book and also one can call the maintenance department but one should always put the request in the log book too. LPN # 1 stated that maintenance is very good about getting any requests completed.

During an interview on 10/6/16 at 12:15 P.M. with CNA (certified nurse's assistant) # 12, CNA # 12 was asked what is done if there are adhesive bandages on the floor in the shower rooms. CNA # 12 stated that one would clean up the adhesive bandages and then contact housekeeping to come and disinfect the area.

During an interview on 10/6/16 at 10:10 a.m. ASM (administrative staff member) # 1, the administrator, was made aware of these observations and a request for any policies was made al this time. An opportunity was given to present any documentation that was available.

Review of the facility policy "Maintenance"

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presented by ASM # 4, Regional director, on 10/6/16 at 1:10 p.m. documented the following: under "Policy" "The facility's physical plant and equipment will be maintained through a program of preventive maintenance and prompt action to identify areas/items in need of repair." Under "Procedure: The Director of Environmental Services will follow all policies regarding routine periodic maintenance. The Director of Environmental Services will perform daily rounds of the building to ensure the plant is free of hazards and in proper physical condition. All employees will report physical plant areas or equipment in need of repair or service to their supervisor. All items needing maintenance assistance will be reported to maintenance using the Maintenance Repair Request form (Attachment A). The form will be completed and placed in a designated area on the nursing unit or in the maintenance office. Environmental Services personnel will check for completed forms throughout the day. The Requests will be prioritized and completed according to need. If unable to complete the request in a reasonable period of time, the originator will be notified as to the current status and further resolution."

Review of the facility policy "DUST MOPPING" presented by OSM # 5 on 10/6/16 at 11:45 a.m. documented the following: under "WASHROOM: always use dust mop before bringing water into room. Pick up trash & debris at door. HALLWAYS AND COMMON AREAS: Use larger dust mop when working in halls. Run mop along baseboard then mop back using a "figure 8" motion. Pick up trash."

An additional policy: "Job: Step 4, Sanitize Sink and Tub" under "Step # 3 Clean and Sanitize

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F 465	Continued From page 121 Shower Stall 1. Spray sanitizer on walls and fixtures and wipe, use brush as needed" Another policy "Hospitality Services" documented under "Policy: Standards for routine cleaning of all interior spaces will be followed, including, but not limited to patient rooms, patient and public baths, tub and shower rooms, closets, utility rooms, offices, diet kitchens, storage spaces, TV and sitting rooms..." Under "Procedure: The Hospitality Services Supervisor will:.. Ensure the cleanliness of all interior areas indicated above...Be familiar with regulations relating to cross contamination and the spread of infectious diseases and shall train staff and monitor compliance..." No further information was provided by the end of the survey.	F 465		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced	F 514	F 514 (1)The urinalysis laboratory results that were misfiled in resident #17's chart were correctly filed. The laboratory file misfiled in resident #6's chart was correctly filed. The laboratory results and the urinalysis results were filed in the appropriate clinical record. (2) All residents have the potential to be affected by this practice. The facility will conduct an audit of 100% of the resident medical records to identify any charts/clinical records with misfiled resident information. (2) All residents have the potential to be affected by this	

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by:
Based on staff interview, clinical record review and facility document review, it was determined that facility staff failed to maintain a complete and accurate clinical record for two of 32 residents, Residents #17 and 6.

1. The facility staff filed a urinalysis (1) laboratory result for two different residents in Resident #17's chart.

2. For Resident #6, another resident's laboratory (lab) results were filed on the clinical record.

The findings include:

1. Resident #17 was admitted to the facility on 2/13/13 and readmitted on 8/6/15 with diagnoses that included but were not limited to lung cancer, difficulty in walking, acute respiratory failure and Alzheimer's Disease.

Resident #17's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/25/16. Resident #17 was coded as being severely cognitively impaired in the ability to make daily decisions scoring 99 on the BIMS (Brief Interview for Mental Status Exam). Resident #17 was coded as requiring extensive assistance from staff with transfers and eating; and totally dependent on staff with dressing, personal hygiene and bathing.

Review of Resident #17's clinical record revealed two different urinalysis laboratory results for two different residents dated 8/24/16 and 8/25/16, in her chart.

practice. The facility will conduct an audit of 100% of the resident medical records to identify any charts/clinical records with misfiled resident information.
(3) The facility will review policies and procedures ensuring knowledge of proper filing of resident information with nursing staff and medical records department. Audits will be conducted weekly x 3 months for 5 residents charts to ensure compliance.

(4) The Quality Assurance/Performance Improvement (QAPI) team will conduct periodic audits to identify any noncompliance.

Completion Date: 11-7-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/06/201

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	905 THOMPSON STREET ASHLAND, VA 23005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE
F 514	Continued From page 123	F 514		

On 10/6/16 at 9:10 a.m., an interview was conducted with RN (Registered Nurse) # 1, the unit manager. RN #1 stated that once nursing receives a laboratory result, the result is faxed to the physician and placed in the clinical record by nursing.

On 10/6/16 at 2:13 p.m., an interview was conducted with ASM (administrative staff member) #4, The Regional Director of Nursing Services. When asked who was responsible for filing laboratory tests, she stated that either the nursing staff or medical records filed labs. She stated that the two labs in Resident #17's chart that belonged to the two different residents should not have been in the clinical record.

On 10/6/16 at 2:30 p.m., ASM #2, the DON (Director of Nursing) was made aware of the above concerns. She stated that when labs come into the facility, it is faxed to the physician either by the nurses or medical records and then placed in the clinical record.

The facility policy titled, "Clinical/Medical Records," documented in part, the following: "Clinical Records are maintained in accordance with professional practice standards to provide complete and accurate information on each resident for continuity of care. The clinical record shall contain - information to identify the resident clearly; a record of the resident's assessments; the plan of care and services; the results of pre-admission screening...In addition, the resident's clinical record shall be readily accessible and systemically organized to facilitate retrieving and compiling information."

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURV COMPLETEI
	495362	A. BUILOING _____ B. WING _____	C 10/06/20

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 514	Continued From page 124	F 514		

No further information was presented prior to exit.

(1) Urinalysis-A urinalysis is a test of your urine. It is often done to check for a urinary tract infections, kidney problems, or diabetes. This information was obtained from The National Inslitutes of Health. https://medlineplus.gov/urinalysis.html.

2. For Resident #6, another resident's lab results were filed on the clinical record.

Resident #6 was admitted to the facility on 6/23/16, with diagnoses including but not limited to: dementia, chronic obstructive pulmonary disease, rib fracture, dysphagia, high blood pressure, hypothyroidism, and psychosis.

The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 6/30/16. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for hygiene, eating, dressing, and transfers; and was coded as incontinent of bowel and bladder.

A review of the clinical record for Resident #6 revealed a lab result of a urinalysis (1) obtained on 9/19/16, which had another resident's name on it.

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	495362	A. BUILDING _____ B. WING _____	C 10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 514	Continued From page 125 On 10/6/16 at 8:20 a.m., in an interview with LPN #5 (Licensed Practical Nurse), she stated that the night shift usually files the labs on the record, and it should have been filed correctly. On 10/5/16 at 5:12 p.m., the Administrator (ASM #1 - administrative staff member #1) was made aware of the findings. No further information was provided by the end of the survey.	F 514		

State of Virginia

PRINTED: 10/18/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 10/4/16 through 10/6/16. Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 190 certified bed facility was 162 at the time of the survey. The survey sample consisted of 26 current resident reviews (Residents #1 through #22 and #29 through #32) and six closed record reviews (Residents #23 through #28).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: 12VAC5-371-250 Resident Assessment and care planning - F278 12VAC5-3731-250 Policies and procedures - F226 12VAC5-371-140 Policies and procedures - see citation below: Based on staff interview and facility document review, it was determined that the facility staff failed to ensure a licensure verification was	F 001	F001 (1) A criminal background check has been obtained on the employee whose file was cited. (2) The facility will conduct a 100% audit of all employee files to identify any employees without the required criminal background check. (3) Facility will (a) review its policies and procedures ensuring that all employees have a criminal background check completed within thirty days of hire. (b) The NHA and the HR Director will sign/initial the criminal background check of each employee within three business days of its receipt, as well as a pre-hire checklist completed with said signatures completed. (4) The Quality Assurance/Performance Improvement (QAPI) team will conduct periodic audits to identify any noncompliance. Completion Date: 11-7-16	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	10/06/2016

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ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 001	Continued From Page 1 obtained in accordance with the laws of the State of Virginia, for one of 25 employee records reviewed and a reference check completed for two of the 25 employee records reviewed. The findings included: Review of the state regulation 12VAC5-371-140 documents "E. Personnel policies and procedures shall include, but are not limited to: 3. An accurate and complete personnel record for each employee including: a. Verification of current professional license, registration, or certificate or completion of a required approved training course;" On 10/6/16 a review of 25 employee records of new hires for the last two years was conducted. This review revealed the following: 1) OSM (other staff member) #2, physical therapist, was hired on 2/29/16, the facility staff failed to obtain a license verification at the time of hire at this facility. Documentation was not included in their employee files that indicated that a license check had been requested from any person. 2) CNA (certified nursing assistant) #21 was hired on 10/12/15, the facility staff failed to obtain reference checks at the time of hire at this facility. Documentation was not included in their employee files that indicated that a personal reference check had been requested from any person. 3) CNA #22 was hired on 4/18/16, the facility staff failed to obtain reference checks at the time of hire at this facility. Documentation was not included in their employee files that indicated that a personal reference check had been requested	F 001		

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F 001	Continued From Page 2 from any person. On 10/6/16 at approximately 1:15 p.m., ASM (administrative staff member) #1, the Administrator and OSM #18 (the human resources director) were aware of the missing documentation in the above referenced employee records. ASM #1 and OSM #18 were asked what should be in each employee record prior to or at the time of hire. OSM #18 stated, "Reference checks, license verification, a state background check and a drug screen." OSM #18 was asked the purpose of obtaining these documents. OSM #18 stated, "To protect the residents. It is part of the abuse policy, it is prevention." OSM #18 further stated that he could not speak to why these documents were not in the employee records as required; he had not been working at the facility for very long but was working on improving the process for employee verifications. A review of the facility policy "Resident Abuse" revealed, in part, the following documentation: "Screening: Persons applying for employment with a The (sic) Company facility will be screened for a history of abuse, neglect, or mistreating residents to include: References from previous or current employers (with applicant permission). Criminal Background check. Abuse check with appropriate licensing board and registries, prior to hire. Swom Disclosure Statement prior to hire. Verify license or registration prior to hire." No further information was provided prior to the end of the survey process. 12 VAC 5 - 371 - 160 E cross references to Federal Deficiency 160	F 001		

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F 001	Continued From Page 3 12 VAC 5 - 371 - 180 A + C cross references to Federal Deficiency 441 12VAC5-371-140. Policies and procedures - Cross reference to F371, and F514 12VAC5-371-360. Clinical records - Cross reference to F514 12VAC5-371-220 A, D Nursing Services- cross reference F246 12VAC5-361-220. Nursing Services cross references to F309. 12VAC5-371-200. Director of Nursing cross references to F282. 12 VAC 5-371-110 (A) Management and Administration -- Cross Reference to F 167 12 VAC 371-370 (A) Maintenance and Housekeeping -- Cross Reference to F 253 & F 465	F 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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K 000	INITIAL COMMENTS K000 Description of structure: One Story with a construction type of type II(000) Sprinkler status: Fully sprinklered in accordance with NFPA-13 An unannounced Recertification Life Safety Code survey was conducted 10/20/16 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2000 Existing regulations. The facility was not in compliance with the Requirements for Participation Medicare and Medicaid. The findings that follow demonstrate non-compliance with Title 42 Code of Regulations, 483.70(a) et seq (Life Safety from Fire.)	K 000	*Ashland Nursing and Rehabilitation ("Facility") is filing this plan of correction for purposes of regulatory compliance. The Facility is submitting this plan of correction to comply with the applicable law. The submission of the plan of correction does not represent an admission or statement of agreement with respect to the alleged deficiencies.*	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This Standard is not met as evidenced by: Based upon observations the fire rated smoke barrier walls have penetrations, joints and openings that are not fire stopped and could allow smoke to pass from one side of the smoke barrier to the other side.	K 025	KO25 Step 1. -All penetrations, joint, and openings have been sealed thus preventing the passage of smoke from one side of the smoke barrier to the other.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: E&RMCE — TITLE: Administrator — (X6) DATE: 11/2/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Step 2.
-All residents within the facility have the potential to be affected by deficient/inadequate facility maintenance practices.

Step 3.
-The relative regulation will be reviewed by the Administrator, Maintenance Department employees, and Environmental Services Department employees.

-The facility's Policies and Procedures related to proper maintenance of smoke barriers will be reviewed.

-Policies/Procedures will be generated/revised if required.

-Appropriate staff (Administrator, Maintenance Dept, Environmental Services Dept.) will be educated regarding said Regulations/Policies/Procedures/Revisions and the importance of compliance.

Step 4.
-Compliance will be monitored via the Quality Assurance Performance Improvement (QAPI) process.

-Audits to identify ineffective smoke barriers will be

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	495362	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 1 Findings include: Between 3:00 PM and 7:20 PM on 10/20/16 it is observed that there are penetrations above the ceilings in the fire rated smoke barrier walls that have not been fire stopped with a listed design and product in Wing 2 Back Hall above the cross corridor doors near room 220, and by Wing 3 Front Hall above the cross corridor doors near room 314.	K 025	conducted monthly X 3 months to verify compliance. -Results will be reported at the monthly QAPI Meeting as appropriate. Step 5. -Date of completion: 11-8-16	
K 048 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This Standard is not met as evidenced by: K48 Based upon observations and reviews of documentation that the emergency evacuation plan does not contain all of the required information in the plan.. Findings include: Between 3:00 PM and 7:20 PM on 10/20/16 during review of the emergency evacuation plan the facility did not have the complete documentation for the fire evacuation plan. The plan was out of date, it did not contain a diagram that shows the location of the smoke compartments, the location of the fire extinguishers, pull stations, locations for defend in place and alternate routes of evacuation. The written plan does not contain the staff assignments and duties of staff, and contact information.	K 048	K048 Step 1. -An updated emergency evacuation plan has been developed including complete documentation and diagrams which address all aspects necessary for an adequate plan. Step 2. -All residents within the facility have the potential to be affected by deficient/inadequate evacuation plan.	
K 060 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Initiation of the required fire alarm systems shall	K 060		

Step 3.
-The relative regulation will be reviewed by the Administrator, Maintenance Department employees.

-The facility's Policies and Procedures related to evacuation will be reviewed.

-Policies/Procedures will be generated/revised if required.

-Appropriate staff will be educated regarding said Regulations/Policies/Procedures/Revisions, their specific role(s) in the evacuation process, and the importance of compliance.

Step 4.
-Compliance will be monitored via the Quality Assurance Performance Improvement (QAPI) process.

-Audits to identify evacuation plan deficiencies will be conducted monthly X 3 months to verify compliance.

-Results will be reported at the monthly QAPI Meeting as appropriate.

Step 5.
-Date of completion: 11-8-16

K060

Step 1.
-The sprinkler system has been repaired by Simplex Grinell such that when the system experiences a water flow condition, a signal to alarm the building fire alarm system and not as a supervisory alarm.

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	495362	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/20/2016

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ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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K 060	Continued From page 2 be by manual fire alarm initiation, automatic detection, or extinguishing system operation. 18.3.4.2, 19.3.4.2, 9.6.2.1 This Standard is not met as evidenced by: K60 Based upon review of documentation and observations that when a water flow of the sprinkler system that the sprinkler system does not send a signal to alarm the building fire alarm system. Findings include: Between 3:00 PM and 7:20 PM on 10/20/16 during review of documentation of the sprinkler inspection report, the report noted that the flow switch for the sprinkler system when in a flow condition that it reported to the fire alarm system as a supervisory alarm and not as a building fire alarm.	K 060	Step 2. -All residents within the facility have the potential to be affected by a deficient/inadequate fire control system. Step 3. -The relative regulation will be reviewed by the Administrator and all members of the Administrative team. -The facility's Policies and Procedures related to fire safety will be reviewed relative to the applicable regulation. -Staff will be educated regarding said Regulations/Policies/Procedures/Revisions and the importance of compliance relative to resident safety.	
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 This Standard is not met as evidenced by: Based upon observations there are doors that are equipped with magnetic locks and all of the required elements are not installed on the door and . Findings include: Between 3:00 PM and 7:20 PM on 10/20/16 it is observed that the egress door from the southern end of the service corridor is equipped	K 072		

Step 4.
-Compliance will be monitored via the Quality Assurance Performance Improvement (QAPI) process.

-Periodic audits to identify inoperative sprinkler water flow switches will be conducted Monthly X 3 months to verify appropriate function.

-Results will be reported at the monthly QAPI Meeting as appropriate.

Step 5.
-Date of completion: 11-8-16

K072

Step 1.
-The egress door from the southern end of the corridor has been posted with directions for operating/unlocking it. The egress door from the Maintenance Office has been repaired. It no longer hits the frame and does not require excessive force to open.

Step 2.
-All residents/staff within the facility have the potential to be affected by a deficient/inadequate system of egress.

Step 3.
-The relative regulation will be reviewed by the Administrator and all members of the Administrative team.

-The facility's Policies and Procedures related to fire safety and adequate egress will be reviewed relative to the applicable regulation.

-Policies/Procedures will be generated/revised if required.

-Staff will be educated regarding said Regulations/Policies/Procedures/Revisions and the importance of compliance relative to resident/staff safety.

Step 4.
-Compliance will be monitored via the Quality Assurance Performance Improvement (QAPI) process.

-Periodic audits to identify violations of egress policy will be conducted monthly X 3 months to verify appropriate function.

-Results will be reported at the monthly QAPI Meeting as appropriate.

Step 5.
-Date of completion: 11-8-16

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ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 072	Continued From page 3 with a time delay magnetic lock and the sign for the directions on how to operate and unlock the door was not located on the door. Between 3:00 PM and 7:20 PM on 10/20/16 it is observed that the door to the maintenance office is hitting the frame and requires excessive force to open the door in the direction of egress.	K 072	-Periodic audits to confirm the presence of updated MSDS Manuals in the appropriate locations will be conducted monthly X 3 months to verify compliance. -Results will be reported at the monthly QAPI Meeting as appropriate. Step 5. -Date of completion: 11-8-16	
K 130 SS=C	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by: K130 Based upon observations that the MSDS books were not up to date. Findings include: Between 3:00 PM and 7:20 PM on 10/20/16 it is observed that the MSDS books for hazardous material are not up to date in the nurse ' s station in wing 1, and service hall area. Referenced by Virginia Fire Prevention Code Section 5003.4	K 130		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This Standard is not met as evidenced by: Based upon observations the electrical systems and equipment is not being maintained. Findings include: Between 3:00 PM and 7:20 PM on 10/20/16 it is observed that the breakers in the electrical panel by the nurse ' s station in Wing 1 is not labeled as to what circuit and location that the breaker feeds.	K 147	K147 Step 1. -The breaker in question has been labeled appropriately. Other breakers have been inspected to ensure proper labeling.	

Step 2.
- All residents/staff within the facility have the potential to be affected by the absence or improper labeling of electrical circuits.

Step 3.
-The relative regulation/code will be reviewed by the Administrator and the Maintenance Dept.

-The facility's Policies and Procedures related to the maintenance and management of electrical system maintenance will be reviewed relative to the applicable regulation/code.

-Policies/Procedures will be generated/revised if required.

-Appropriate staff (the Maintenance Dept.) will be

educated regarding said Regulations/Codes/Policies/Procedures/Revisions and the importance of compliance.

Step 4.
-Compliance will be monitored via the Quality Assurance Performance Improvement (QAPI) process.

-Periodic audits to confirm proper labeling of electrical panel circuit breakers will be conducted monthly X 3 months to verify appropriateness.

-Results will be reported at the monthly QAPI Meeting as appropriate.

Step 5.
-Date of completion: 11-8-16